The Hitchcock Health Institute Medical History Intake Form

***NAME*: _____DOB: _____Today's Date:_____**

Reason for Visit:

_____

_____

Current Medications:

Name/ Dose/ Frequency

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies & Side Effects of Such:

_____

Past Medical History: (Please Check All That Apply)

☐Alcoholism ☐Eating disorder ☐Migraines ☐Anemia ☐Epilepsy ☐Osteoporosis ☐Anxiety ☐ Gout
☐Pneumonia ☐Asthma ☐Heart Disease ☐Stroke ☐AIDS/HIV ☐Hepatitis ☐Substance Abuse ☐Back Issues
☐High Blood Pressure ☐Thyroid ☐Bleeding Disorder ☐High Cholesterol ☐Venereal disease ☐Diabetes
☐Joint Disorder ☐Depression ☐Kidney Disorder ☐Ear Problems ☐Liver disease

Details:_____

_____

Hospitalizations/Surgeries:

Reason: _____Date:_____ Reason: _____Date:_____
Reason: _____Date:_____ Reason: _____Date:_____
Reason: _____Date:_____ Reason: _____Date:_____
Reason: _____Date:_____ Reason: _____Date:_____

Lifestyle: (Please Check All That Apply)

Do you have sex with ☐men ☐women ☐both Have you ever smoked? ☐Yes for ___ years ☐No
How much alcohol do you drink per week? _____drinks.
Has anyone in your home verbally or physically hurt you? ☐Yes ☐No

Family History

Marital Status (Please Circle) M S D W ***Number of children:*** _____

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Has anyone in your family had the following conditions? (Please Check All That Apply)

☐Alcoholism ☐Diabetes ☐Liver Disorder ☐Alzheimer's ☐Genetic Disorder ☐Lung Disease ☐AIDS/HIV ☐Heart Disease ☐Migraines ☐Blood Dis. ☐High Cholesterol ☐Psychiatric ☐Cancer ☐High Blood Pressure ☐Stroke ☐Depression ☐Kidney Disease ☐Thyroid Disorder

Details_____

_____

_____

_____

Circle any that you have recently experienced:

CONSTITUTIONAL: Chills, fatigue, fever, weight loss / weight gain.

CARDIOVASCULAR: Chest pain, palpitations

GASTROINTESTINAL: Nausea, vomiting, Diarrhea, heartburn, abdominal pain, constipation

GENITOURINARY: Painful urination, irregular achiness, menstrual cycle, nighttime urination, frequenturination, urinary incontinence

PSYCHIATRIC: Anxiety, depression, sleep Sweating, memory loss, tremor, weakness, disturbance, suicidal thoughts, feeling stressed, mood swings, poor concentration

ENT: Blurred vision, eye pain, ear pain, nasal congestion, hoarseness, sore throat

RESPIRATORY: Cough, shortness of breath, wheezing

HEMATOLOGY: Easy bruising, excessive bleeding

MUSCULOSKELETAL: Back pain, joint stiffness,

SKIN/ BREAST: Acne, dry skin, rash, breast mass, breast tenderness, nipple discharge

ENDOCRINE: Hair loss, hot flashes, excessive

NEUROLOGIC: Dizziness, fainting, headaches,