Hitchcock Health Institute
Medical History Intake Form

NAME: _____ **DOB:** _____ **Today's Date**: _____

Reason for Visit

_____

_____

Current Medications *Please list medication name, dose, and frequency, including daily over-the-counter supplements*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies *Please include reaction and severity*

_____

_____

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 ☐Sexually Transmitted Infection
☐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: _____

Personal History *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

Marital Status *Please check one* **Number of children:** _____
☐Single ☐Married ☐Widowed ☐Divorced

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Family History

Has anyone in your family had the following conditions? *Please check all that apply*
☐Alcoholism ☐Diabetes ☐Liver Disorder ☐Alzheimer's ☐Dementia ☐Genetic Disorder ☐Lung Disease ☐AIDS/HIV ☐Heart Disease ☐Migraines ☐Blood Disorders ☐High Cholesterol ☐Psychiatric ☐Cancer ☐High Blood Pressure ☐Stroke ☐Depression ☐Kidney Disease ☐Thyroid Disorder ☐ Neurological Disease

Details:_____
_____
_____
_____
_____
_____

Review of Systems *Please circle all that you have experienced within the last 6 months*

CARDIOVASCULAR: chest pain, palpitations, fainting, leg pain with walking

CONSTITUTIONAL: chills, fatigue, fever, weight loss, weight gain

ENDOCRINE: Hair loss, hot flashes, excessive thirst, excessive hunger, irregular menstrual cycle

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

HEMATOLOGY: easy bruising, excessive bleeding

GASTROINTESTINAL: nausea, vomiting, diarrhea, heartburn, abdominal pain, constipation, blood in stool

GENITOURINARY: painful urination, irregular achiness, nighttime urination, frequent urination, urinary incontinence, pelvic pain

LYMPHATIC: swollen glands, swelling of arms/legs

MUSCULOSKELETAL: back pain, neck pain, joint stiffness

NEUROLOGICAL: dizziness, headaches, memory loss, confusion, tremor, arm or leg weakness, numbness/tingling, seizures

PSYCHIATRIC: anxiety, depression, night sweats, sleep disturbance, suicidal thoughts, feeling stressed, mood swings, poor concentration

RESPIRATORY: cough, shortness of breath, wheezing, coughing blood

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

OTHER: _____