Partners *in* Health Management
Diabetes Education • Healthcare Services

PARTNERS IN HEALTH
MEDICAL HISTORY FORM

Patient Name: **DOB:**

Allergies: (medications, foods or plants)

MARK AN (X) If you HAD or HAVE at present	Yes		Yes		Yes		Yes
Heart problems or chest pain		Shortness of breath		Sickle cell disease		Enlarged glands or lymph nodes	
Fever/Chills		Chronic cough		Yellow jaundice		Limited movement	
Heart murmur		Tuberculosis (TB)		Blood transfusion		Ankles swell	
Rheumatic fever		Asthma		Drug addiction		Fainting or dizzy spells	
High blood pressure		Hay fever		More than 5 drinks per day		Tire easily	
Heart pacemaker		Sinus trouble		Hemophilia		WOMEN:	
Artificial heart valve		Use tobacco products		Stomach pain		Menarche	
Sleep on more than 2 pillows or sleep problems		Lung disease or frequent respiratory infections		Gained or lost more than 10 pounds in past year		Birth Control Last Menstrual Period:	
Thyroid disease		Smoker in house		Epilepsy or seizures		Anticipate becoming pregnant?	
Stroke		Vision problems		Nervousness/anxiety		Pregnant Now?	
Hepatitis/Liver disease		Hearing problems Ear aches		Psychiatric treatment		Number of children?	
Artificial joint		Flu shot Pneumonia Shot Zoster Shot		Domestic Violence		Menstruation problems? Menopause ☐ Yes ☐ No Age_____	
Anemia		Lead poisoning		Excessive bleeding		Last Mammogram	
Diabetes		Chemotherapy/Radiation		Special diet		Last PAP:	
Kidney trouble		Arthritis		Persistent diarrhea/constipation			
Problems with urination		Cortisone medicine		Nausea or vomiting		Social Questions:	
Ulcers		Glaucoma		Genital sores		Do you smoke? How long? How many?	
Emphysema		HIV/AIDS		Sexually transmitted disease		Do you drink? How often?	
Cancer or tumor		White or blue patches in mouth		Bad breath			

Please state your last colonoscopy o er

List all Health Professionals you have visited outside of our clinic within the past 2 years and for what reason.

Have you had any surgeries? Yes/No If yes, please explain type of surgery and at what hospital or surgery center.

Please list all your medications (include non-prescription)

To the best of my knowledge all the answers are true and correct. If I ever have any change in my health I will inform my doctor.

Provider Signature **Date** **Patient Signature** **Date**