

Grace Place Resident Medical History

Patient's Name: _____

Today's Date: _____

Social Security Number: _____

Date of Birth: _____

Past Medical History

Previous Physician's name: _____

Date of last exam: _____

Have you ever been hospitalized? Yes No

If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? Yes No

Which hepatitis virus? _____

Have you been vaccinated for hepatitis B? Yes No

If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? Yes No

If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____

Result of TB screening: Positive Negative

If positive TB screen, date of last chest x-ray: _____

Result of chest x-ray: Positive Negative

Have you had a sexually transmitted disease? Yes No

Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart disease / Murmur / Angina | <input type="checkbox"/> Shortness of breathe | <input type="checkbox"/> Eye disorder / Glaucoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney / Bladder problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems / cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver problems / Hepatitis |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Thyroid problems |

Please describe any current or past medical treatment not listed above

Please list your past surgeries

Allergies

Are you allergic to penicillin or any other drugs? Yes No

Please list:

Medications

Please list:

Social and Preventive History

Do you currently smoke or chew tobacco? Yes No
How many packs per day? _____

If no, have you in the past? Yes No

Do you drink alcohol, beer, or wine? Yes No
How many drinks per week? _____

If no, have you in the past? Yes No

Do you currently drink coffee and/or tea? Yes No

If yes, how many cups per day? _____

Do you exercise daily/weekly? Yes No

Do you use seatbelts while driving? Yes No

Do you wear a helmet while riding a bike? Yes No

Family History

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List serious illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Females: Gynecological History

How many times have you been pregnant? _____

Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? Yes No

Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? Yes No

Diagnosis: _____

Date of last mammogram: _____

Mammogram results: _____

Have you ever had a breast biopsy? Yes No

Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____

Date _____