TODAY'S DATE:_____

NAME: _____ DATE OF BIRTH:_____

ISLAND HEALTH CARE PATIENT MEDICAL HISTORY FORM

Are you allergic to latex or rubber? □ Yes □ No

ALLERGIES TO MEDICATIONS: □ None □ Yes, please list _____

_____

CURRENT MEDICATION LIST

Please list all medications taken, including "Over The Counter" supplements.

If NONE, check here □

MEDICATION	DOSAGE	COMMENTS

Do you have or have you ever been treated for any of the following health problems? (Check box)

□ Anemia	□ *Cancer	□ Headaches	□ High Blood Pressure	□ Seizure Disorder
□ Arthritis	□ Chest pain/ Angina	□ Heartburn	□ Kidney Disease	□ Stroke
□ Asthma	□ Depression	□ Heart murmur	□ Liver Disease	□ Thyroid Disease
□ Blood Disorder	□ Diabetes	□ Hepatitis A or C	□ Mental illness	□ Tuberculosis
□ Bronchitis	□ Glaucoma	□ HIV/AIDS	□ Pneumonia	□ Ulcers
□ Bowel Disease	□ Gout	□ High Cholesterol	□ Prostate Enlargement	□ Impaired Vision

□ Other (list) _____

□ **I HAVE NONE OF THE ABOVE**

*If you have had cancer, what type? _____

For women: Is there a possibility you are pregnant? □ Yes □ No
When was your last menstrual period? _____
□ Postmenopausal or Hysterectomy

Do you currently have any of the following symptoms?

General	□fever	□ weight loss	□ malaise	□ excessive daytime sleepiness
Eye	□ vision loss	□ double vision	□ floaters	□ flashes of light
Ears, nose, mouth, throat	□ hearing loss/ear pain	□ snoring	□ sore throat	□ sinus/face congestion
Heart	□ chest pain/discomfort	□ palpitations	□ passing out	□ shortness of breath with exertion
Lungs	□ cough	□ pain with breathing	□ wheezing	□ short of breath
Stomach/ Intestines	□ heartburn	□ constipation	□ diarrhea	□ trouble swallowing
Genital/ Kidney	□ blood in urine	□ frequent urination	□ painful urination	□ male/ female issues
Muscles/ joints	□ joint pain/swelling	□ muscle ache	□ back pain	
Skin	□ rash	□ itchy ears	□ non healing wound	□ change in mole
Neurological	□ dizziness	□ weakness	□ headache	□ memory loss
Psychiatric	□ depressed	□ anxiety/panic	□ focus/memory problm	□ irritability
Hormones	□ heat intolerance	□ cold intolerance	□ moodiness	□ thirst
Blood/ Lymph	□ easy bruising	□ swollen glands	□ bleeding	□ swollen arms/legs
Allergic	□ spring allergies	□ fall allergies	□ summer allergies	□ winter allergies
Other (list)				

HEALTH HABITS AND PERSONAL SAFETY

Exercise: □ Sedentary (no exercise)
□ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)
□ Occasional vigorous exercise (i.e. work or recreation, less than 4x/wk for 30 min.)
□ Regular vigorous exercise (i.e. work or recreation, 4x/wk for 30 min.)

Diet: Are you dieting? □ Yes □ No
If yes, are you on any physician prescribed medical dieting? □ Yes □ No
Number of meals you eat in an average day: _____
Rank of salt intake: □ High □ Medium □ Low
Rank of fat intake: □ High □ Medium □ Low
Rank of fruit and vegetable intake: □ High □ Medium □ Low

Are you sexually active? □ Yes □ No

Any discomfort with intercourse?

Illness related to the Human Immunodeficiency Virus (HIV) such as AIDS has become a major public health problem. Risk Factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with you provider about your risk for this illness? □ Yes □ No

Do you live alone? □ Yes □ No

Do have vision or hearing loss? □ Yes □ No

Do you have an advanced directive or Living Will? □ Yes □ No
Would you like information on the preparation of these documents? □ Yes □ No

Physical or mental abuse have also become a major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? □ Yes □ No

Caffeine: □ None □ Coffee □ Tea □ Coke
# of cups/ cans per day

Alcohol: Do you drink alcohol? □ Yes. What kind? _____ □ No
How many drinks per week? ____
Are you concerned about the amount you are drinking? □ Yes □ No
Have you considered stopping? □ Yes □ No
Have you ever experienced blackouts? □ Yes □ No
Are you prone to "binge" drinking? □ Yes □ No
Do you drive after drinking? □ Yes □ No

Tobacco: Do you use tobacco? □ **YES** □ Cigarettes ___ pks/day □ Chew ___ #day □ Pipe ___ #day
□ Cigars ___ #day # of years: ____

□ **NO** How many years quit? ____

Drugs: Do you currently use recreational or street drugs? □ Yes □ No
Have you ever given yourself street drugs with a needle? □ Yes □ No

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic fever □ Polio

Education: Last year of school _____

Family Health History: Were you adopted? □ Yes □ No

Please note the ages and significant health problem any of these close relatives have been diagnosed with:

	Age	Significant Health Problem		Age	Significant Health Problem
Father			Children	□ M □ F	
Mother				□ M □ F	
Siblings	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		Grandmother *Maternal*		
	□ M □ F		Grandfather *Maternal*		
	□ M □ F		Grandmother *Paternal*		
	□ M □ F		Grandfather *Paternal*		

How can we help you today?