Mercy
MEDICAL SERVICES
A partner with Mercy Medical Center-Sioux City

ADULT PATIENT HISTORY

Please complete to the best of your ability to assist our staff in providing the best possible care for you and/or your family members.

LAST NAME _____ **FIRST NAME** _____ **MI** _____

DATE OF BIRTH _____ **PRIMARY LANGUAGE** _____ **MALE/FEMALE**_____

CHRONIC PROBLEMS (CONDITIONS) (for example: diabetes, hypertension, depression or etc.) **NONE** ☐

Name of Condition	Date of Onset	Additional information

MEDICATIONS (if you need more space for medications please ask for another form) **NONE** ☐

Name of Medication	Dosage	How many times per day	Date Started	Prescribed By

ALLERGIES (**circle and explain type of reaction below**): Medication, Household Products, Animals, Environment

_____

_____

_____

_____

PAST MEDICAL HISTORY (please mark all that apply and year of onset) **NONE** ☐

Date	Medical Problem	Date	Medical Problem	Date	Medical Problem
	Alcohol/Drug Problem		Crohn's Disease		Irritable Bowel Disease
	Allergies/Hay Fever		CVA/Stroke		Liver Problems
	Arthritis		Depression		Migraine Headaches
	Asthma/Lung problems		Diabetes		MRSA/VRE
	Atrial Fibrillation		GERD (Stomach Reflux)		Osteoporosis
	Bladder/Kidney Infections or Stones		Glaucoma		Seizures
	Bleeding/Clotting		Heart Disease/Heart Attack		Sexually Transmitted Disease
	Blood Transfusion		Hepatitis C		Thyroid Disease
	Cancer:_____		High Blood Pressure		Tuberculosis
	COPD		High Cholesterol		Other:
	Coronary Artery Disease		High Lipid Level		Other:

Additional past medical history information: _____

_____

_____

_____

PAST SURGICAL/HOSPITALIZATION HISTORY (any surgeries or hospitalizations along with dates) **NONE** ☐

Date	Surgery/Hospital Stay	Date	Surgery/Hospital Stay

Additional past surgical history information: _____

_____

_____

FAMILY MEDICAL HISTORY ☐ No relevant family history

Medical Problem	Relative	Age at onset or death	Medical Problem	Relative	Age at onset or death	Medical Problem	Relative	Age at onset or death
Alcohol/Drug			Diabetes			Mental illness		
Allergies			Stomach/intestine			Migraine		
Alzheimer			Bladder/Kidney			Lung problem		
Anesthesia			Heart			Stroke		
Arthritis			Blood pressure			Thyroid		
Asthma			Cholesterol			Cancer		
Blood disease			Other			Other		

Additional Family History Information _____
_____
_____
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Tobacco use

- ☐ None in household
- ☐ Quit: packs/day_____ years smoked:_____ quit date:_____ type of tobacco:_____
- ☐ Current smoker: packs/day_____; start date:_____ type of tobacco:_____
- ☐ Second-hand smoke (who in home smokes) _____

Alcohol use (each drink contains 0.5 oz alcohol): (answer for children over 12 years of age)

- ☐ No
- ☐ Yes: Drink(s) per week:_____ Type of alcohol _____

Substance Abuse

- ☐ Yes Type _____ Amount_____ How often_____
- ☐ No

Nutrition and Activity

- ☐ Caffeine (coffee, tea, soda): ☐yes ☐no, if yes, how much per day:_____
- ☐ Diet: ☐good /☐fair /☐bad /☐vegetarian /☐vegan
- ❑ Exercise: types:_____ min per day: _____; times per week:_____

Social and Special needs

- ❑ Do you feel safe at home: ☐yes / no ☐
- ❑ Do you have communication needs that affect your medical care: ☐yes ☐no ; if yes explain:_____

Obstetrics (for women)

How may times have you been pregnant: _____ age of first pregnancy _____
Number of full term pregnancy (>37 weeks)_____ Number of preterm pregnancy (< 37 weeks) _____
Number of miscarriage:_____ Number of abortion_____ Number of ectopic pregnancy_____
Number of multiple births_____ Number of living children_____

Health Care Maintenance (please <u>enter dates:</u> also write N for "normal" or AN for "abnormal"):

Last Physical_____ Last Dental Exam _____ Last eye exam _____
Immunizations Up-To-Date_____
Last Pap Smear (woman)_____ Last Mammogram (woman) _____
Last Colonoscopy_____ Last Lipid Profile_____
Last DEXA (bone density)_____ Last Fasting Blood Sugar_____
Last Hemoglobin A1c (Diabetes test)_____

Form completed by _____ Date _____

REV. 11/28/11