MERCY HEALTH SYSTEM

General Medical History Form: ADULT

Name:	**Date:**	**DOB:**
Home Phone # ( )	**Work Phone # ( )**	**E-mail Address:**
Marital Status: ❑Divorced ❑Separated ❑Married ❑Sig Other ❑Single ❑Widowed ❑Other		
Maiden/Other Names: (1)	(2)	(3)
Emergency Contact 1:	Relation:	Hm:( ) Wk or Cell:( )
Emergency Contact 2:	Relation:	Hm:( ) Wk or Cell:( )
Occupation:	**Employer**	**Business Phone**
Ethnic Group: ❑African American ❑Caucasian ❑Hispanic/Latino ❑Asian ❑American Indian ❑Other please specify		
Language Preference:	**Cultural Needs and Preferences:**	
Interpreter Needed? ❑ **Language:**	**Educational Barriers:**	
Allergies (include date if known):		**Health concerns to be addressed at appointment:**
Medications (include dose if known) Nurse will review medications with you.		

Patient's Medical History **Are you adopted?** ❑Yes❑No

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Allergies			Chronic lung			HIV/AIDS			Skin disease		
Anemia			Colon problems			Kidney disease			Stomach problems		
Arthritis/ Gout			Diabetes			Liver disease			Stroke		
Asthma			Genital problems			Nerve problems			Thyroid disease		
Bleeding/ bleeding disorder			Headaches			Mental Health issues			Tuberculosis		
Blood in stool			Heart disease			Rheumatic Fever			Urinary problems		
Cancer			Hepatitis			Seizures			Vision problems		
Chest pain			High Blood Pressure			Sickle Cell Anemia					

Patient's Surgery/ Procedure History	Yes	No	Date	Patient's Surgery/ Procedure History	Yes	No	Date
Appendectomy				**Mammogram**			
Cardiac Surgery				**Mastectomy**			
Colonoscopy				**Pap Test**			
Dexa Scan				**Prostate Exam**			
Gallbladder Removal				**Vascular Surgery**			
Hysterectomy				**Other**			

MERCY HEALTH SYSTEM

General Medical History Form: ADULT

Tobacco Use: ❑Yes ❑Never ❑Quit ❑Second Hand Comments regarding smoking history: _____
Packs/day:_____ #Years:_____Quit Date:_____ Types: ❑Chew ❑Cigars ❑Cigarettes ❑Pipe ❑Snuff

Alcohol: ❑Yes ❑No Comments regarding alcohol use _____
Drinks/Week:_____ Glass(es) of wine _____Oz/Week _____ Can(s) of beer
_____ Shot(s) of Liquor _____ Drink(s) containing 0.5 oz of alcohol

Drug Use: ❑Yes ❑No Comments regarding drug use_____
Per week_____ Types: ❑ Marijuana ❑ Methamphetamines ❑ Cocaine ❑ IV ❑ **Other**

Activities of Daily Living / Misc:

	Yes	No		Yes	No		Yes	No
Follow a healthy diet			Perform self exams			Wear bike helmet		
Caffeine concern			Follow a special diet			Difficulty walking		
Stress concern			Safe home environment			Exercise regularly		
Occupational exposure			Weight Concern			Wear seatbelt		
Blood transfusion			Practices Back Care			Other		
Second hand smoke exposure								

Check family members who have the following conditions				Addictions	Anesthesia Problems	Arthritis/Joint	Blood Disorder	Cancer	Diabetes	Gastrointestinal	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Mental Health	Respiratory	Seizures	Stroke	Thyroid Disease	Other
Relationship		**Name**	**Status** Alive/ Deceased																	
Parents	**Mother**																			
Parents	**Father**																			
Siblings	**Sister**																			
Siblings	**Brother**																			
Siblings																				
Siblings																				
Grandparent	**Mother's side**																			
Grandparent	**Mother's side**																			
Grandparent	**Father's side**																			
Grandparent	**Father's side**																			
Children	**Daughter**																			
Children	**Son**																			

Immunization	**Date**	**Immunization**	**Date**
Tetanus Booster:		Hepatitis A:	
Chickenpox or (date of illness):		Hepatitis B:	
Influenza:		MMR:	
Pneumovax:		Rubella: Titer date:	Disease date:
Other:		Other:	