CHMG Chicago Health Medical Group

Medical History

General Information

Name: _____ DOB: __ __ / __ __ / __ __ __ __ Age: _____

Social Security Number: __ __ __ / __ __ / __ __ __ __ Sex: ☐ M ☐ F Date (today): __ __ / __ __ / __ __ __ __

Language(s) spoken: ☐ English ☐ Spanish ☐ Polish ☐ Other: _____

Medical History Check all current and past problems.

- ☐ Allergies/hay fever
- ☐ Anemia
- ☐ Anxiety problem
- ☐ Arthritis
- ☐ Asthma/wheezing
- ☐ Back pain
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Bone/joint injuries
- ☐ Cancer
- ☐ Chicken pox
- ☐ Convulsions/seizures
- ☐ Dementia/memory loss
- ☐ Dental/oral disease
- ☐ Diabetes
- ☐ Depression
- ☐ Ear/hearing problems
- ☐ Eating disorder
- ☐ Eye/vision problems
- ☐ Foot problems
- ☐ Gall bladder disease/stones
- ☐ Gastritis/ulcer
- ☐ Gout
- ☐ Headaches/migraine
- ☐ Heart disease
- ☐ Heart rhythm problem
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease/stones
- ☐ Liver disease
- ☐ Lung disease
- ☐ Menstrual problems
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Overweight/obesity
- ☐ Pneumonia
- ☐ Prostate disorder
- ☐ Sexual problems
- ☐ Sexually transmitted disease
- ☐ Skin disease/sores
- ☐ Sleep problems
- ☐ Stomach/digestive disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis (or positive TB test)
- ☐ Urinary problem

Please give details of any items checked, or add information about other problems if they are not listed:

_____

_____

_____

_____

Surgical History List the date and type of any past surgeries.

Date	Surgery	Date	Surgery

Medications List your medications, prescription or non-prescription, including the dose and how often you take them. Please include all types of medicine, including pills, injections, creams and eye drops.

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products)? If so, please list them:

_____

Allergies and Reactions

List any substances that have caused a bad reaction, and write the reaction.
Please include prescription or non-prescription medicines, foods, plants or other materials.

Substance	Reaction	Substance	Reaction

Personal History and Habits

Your answers will be kept confidential.

General

Are you employed? ☐Yes ☐No If yes, what occupation?: _____
Are you? ☐Single ☐Married ☐Divorced ☐Widowed
Are you sexually active? ☐Yes ☐No
Do you have children? ☐Yes ☐No If so, how old are they? _____
Who lives with you in your home? _____
At home, do you need help getting around, dressing, bathing, using the bathroom, or eating? ☐Yes ☐No
If yes, what do you need help with? _____
Do you exercise? ☐Yes ☐No If yes, what activities and how often? _____
When was your last dental exam? _____ Do you wear dentures? ☐Yes ☐No
When was your last vision exam? _____ Do you wear glasses or contact lenses? ☐Yes ☐No
Have you recently or do you often travel outside the U.S.? ☐Yes ☐No If so, where? _____

Substances

Do you use tobacco? ☐Yes ☐No
If no, have you ever used tobacco? ☐Yes ☐No
If yes, what type:
☐ Cigarettes How much and for how long: _____
☐ Cigars How much and for how long: _____
☐ Chewing tobacco How much and for how long: _____

In the past year, have you ever drunk or used drugs more than you meant to? ☐Yes ☐No
In the past year, have you ever thought you should cut down on your drinking or drug use? ☐Yes ☐No
Do you ever get annoyed or angry when people talk to you about your drinking/drug use? ☐Yes ☐No
Do you ever feel guilty about your drinking/drug use? ☐Yes ☐No
Have you ever had an "eye-opener" (morning drink) to get started first thing in the morning? ☐Yes ☐No
How many alcohol-containing drinks do you have in a typical week? (one drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor)
☐0 ☐1-7 ☐8-10 ☐11-13 ☐14-20 ☐21-30 ☐31-40 ☐41 or more

Safety

Have you had any falls within the past 6 months? ☐Yes ☐No
Do you use a cane, walker or other device to help you get around? ☐Yes ☐No
Do you feel unsafe or threatened in any way (at home, work or otherwise)? ☐Yes ☐No
Have you ever been the victim of violence or abuse (including sexual abuse)? ☐Yes ☐No
Have you been hit, kicked or otherwise hurt by someone in the past year? ☐Yes ☐No
Do you feel unsafe in your current relationship? ☐Yes ☐No
Have you been forced to have sex? ☐Yes ☐No
Do you or other family members keep gun(s) in the home? ☐Yes ☐No
Do you wear a seatbelt when you drive? ☐No ☐Yes ☐Sometimes
Do you have smoke detector(s) in your home? ☐No ☐Yes ☐Don't know

Nutrition

What is your usual weight? _____ What is your usual height? _____
Have you had decreased food intake for more than one week? ☐Yes ☐No
Have you unintentionally gained or lost 10 pounds in the last month? ☐Yes ☐No
Do you have difficulty swallowing? ☐Yes ☐No
Are you on a modified or special diet, or on tube feeding? ☐Yes ☐No
(For **women**): Are you pregnant or breast-feeding? ☐Yes ☐No

Family History

Please write which family member(s) have or had the following:

Condition	Family Member(s)	Condition	Family Member(s)
Alcohol / substance abuse		High cholesterol	
Cancer, type: _____		Psychiatric illness	
Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other: _____	

Obstetric/Gynecologic History (for **women** only)

Age of first period? _____ If you no longer have periods, at what age did they stop? _____
Please list: Total # of pregnancies? _____ Abortions? _____ Miscarriages? _____
Do you plan to get pregnant within the next year? ☐Yes ☐No
Are you using any birth control? ☐Yes ☐No If yes, what type?_____

Cancer Screening

Breast Cancer (for **women** only):
When was your last mammogram (year)? _____ ☐Don't remember ☐Never had one
Have you ever had an abnormal mammogram? ☐Yes ☐No ☐Don't know

Cervical Cancer (for **women** only):
When was your last Pap smear (year)? _____ ☐Don't remember ☐Never had one
Have you ever had an abnormal Pap smear? ☐Yes ☐No ☐Don't know

Colon cancer (for **men and women over age 50)**:
Have you ever had a test to see if you had colon cancer? ☐Yes ☐No ☐Don't know

Prostate cancer (for **men** only)
Have you ever had a rectal examination or a "PSA" blood test? ☐Yes ☐No ☐Don't know

Immunizations Have you ever had the following vaccines?:

Tetanus: ☐Yes, Year (most recent): _____ ☐Never ☐Don't know
Flu: ☐Yes, Year (most recent): _____ ☐Never ☐Don't know
Pneumonia: ☐Yes, Year (most recent): _____ ☐Never ☐Don't know

Advance Directives

Do you have a Living Will (instructions about the medical care you want given if you get very sick)? ☐Yes ☐No ☐Don't know

Do you have a Power of Attorney for health care (instructions about who you want to make medical decisions for you if you are not able to make them)? ☐Yes ☐No ☐Don't know

Would you like more information about a Living Will or a Power of Attorney? ☐Yes ☐No

SYMPTOMS – Review of Systems:

Please check all that apply to you

CONSTITUTIONAL:
□ Fever
□ Night sweats
□ Weight gain lbs_____
□ Weight loss lbs_____
□ Exercise intolerance

EYES:
□ Dry eyes
□ Irritation
□ Vision change

EARS, NOSE MOUTH, THROAT:
□ Difficulty hearing
□ Ear pain
□ Frequent nosebleeds
□ Nose/sinus problems
□ Sore throat
□ Bleeding gums
□ Snoring
□ Dry mouth
□ Oral abnormalities
□ Mouth ulcer
□ Teeth abnormalities

CARDIOVASCULAR:
□ Chest pain on exertion
□ Arm pain on exertion
□ Shortness of breath when walking
□ Shortness of breath when lying down
□ Palpitations
□ Known heart murmur
□ Light-headed on standing

RESPIRATORY:
□ Cough
□ Wheezing
□ Shortness of breath
□ Coughing up blood
□ Sleep apnea

GATROINTESTINAL:
□ Abdominal pain
□ Heartburn
□ Vomiting
□ Change in appetite
□ Black or tarry stools
□ Diarrhea
□ Constipation
□ Vomiting blood

GENITOURINARY:
□ Urinary loss
□ Difficulty urinating
□ Increased urinary frequency
□ Blood in urine (hematuria)
□ Incomplete emptying

URINARY FEMALE:
□ Abnormal vaginal discharge
□ Bleeding between periods
□ Breast lump
□ Hot flashes
□ Irregular periods
□ Painful intercourse
□ Severe menstrual pain
□ Sore(s) on genitals

URINARY MALE:
□ Lump in testicle
□ Penis discharge
□ Sore(s) on genitals
□ Inadequacy of penile erection

MUSCULOSKELETAL:
□ Muscle aches
□ Muscle weakness
□ Joint pain
□ Back pain
□ Edema

SKIN:
□ Abnormal mole
□ Jaundice
□ Rash
□ Nail problem
□ Itching
□ Dry skin
□ Growths/lesions

NEUROLOGIC:
□ Loss of consciousness
□ Weakness
□ Numbness
□ Memory/Loss
□ Seizures
□ Dizziness
□ Headaches
□ Migraine
□ Restless legs

PSYCHIATRIC:
□ Depression
□ Anxiety
□ Sleep disturbances/restless sleep
□ Feel unsafe in a relationship
□ Alcohol overuse

ENDOCRINE:
□ Fatigue
□ Increased thirst
□ Hair loss
□ Increased hair growth
□ Cold intolerance

HEMATOLOGIC/LYMPHATIC:
□ Swollen glands
□ Easy bruising
□ Excessive bleeding

ALLERGIC/IMMUNOLOGIC:
□ Runny nose
□ Sinus pressure
□ Itching
□ Hives
□ Frequent sneezing

Reviewed by:

_____ _____

PHYSICIAN **DATE**