

HAMPDEN MEDICAL GROUP PATIENT HISTORY

Patient Name

Name (last, first, mi)

DOB:

Date:

Allergies and Reactions (Please use the back if more space is needed)

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Personal Medical History

In the past I have had or I am currently being treated for:

Allergies	Yes	No	HIV Virus/ AIDS	Yes	No
Anemia	Yes	No	Hyperlipidemia	Yes	No
Angina	Yes	No	Hypertension	Yes	No
Anxiety	Yes	No	Insomnia	Yes	No
Arthritis	Yes	No	Irritable bowel disease	Yes	No
Asthma	Yes	No	Joint Disease	Yes	No
Atrial fibrillation	Yes	No	Kidney or bladder infection	Yes	No
Benign prostatic hypertrophy	Yes	No	Lung disease	Yes	No
Blood clots	Yes	No	Measles	Yes	No
Cancer(s)	Yes	No	Memory Problems	Yes	No
Cerebrovascular accident (Stroke)	Yes	No	Migraine headaches	Yes	No
Chicken Pox	Yes	No	Myocardial infarction (Heart Attack)	Yes	No
COPD (Emphysema)	Yes	No	Osteoarthritis	Yes	No
Coronary Artery Disease	Yes	No	Osteoporosis	Yes	No
Crohn's Disease	Yes	No	Pneumonia	Yes	No
Depression	Yes	No	Peptic ulcer disease or G.E.R.D	Yes	No
Diabetes	Yes	No	Renal disease	Yes	No
Epilepsy or Convulsions	Yes	No	Seizure disorder	Yes	No
Gallbladder Disease	Yes	No	Sickle cell anemia	Yes	No
Gout	Yes	No	Sleep apnea	Yes	No
Heart Disease	Yes	No	STD	Yes	No
Hepatitis C	Yes	No	Thyroid disease	Yes	No
High blood pressure	Yes	No			

Other: _____

Surgical History (Please use the back if more space is needed)

Surgery	Date	Outcome	Performing Doctor

Family History

Do you have any family with the following medical history?

Disease	Which Member	Age of Onset	Cause of Death
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's			
Asthma			
Blood disease			
CAD (Heart Attack)			
Cancer			
CVA (Stroke)			
Depression			
Developmental Delay			
Diabetes			
Eczema			
Hearing Deficiency			
Hyperlipidemia			
Hypertension			
Irritable Bowel Syndrome			
Learning Disability			
Mental Illness			
Migraines			
Obesity			
Osteoarthritis			
Osteoporosis			
Peripheral Vascular Disease			
Renal Disease			
Seizure Disorder			

Other: _____

Females

Last period: _____

Total pregnancies: _____

Currently pregnant? _____ Yes No

Last mammogram _____

Last Pap smear _____

Social History

Birthplace: _____

Hand dominance: Right Left

Language spoken: _____

Marital Status

Status: _____

Education/ Employment/ Occupation/ Military Experience

Education

Last grade completed: _____

Did you graduate? _____ Yes No

Degree: _____

Continued Education: _____

Learning Disability? _____ Yes No

Special Needs? _____ Yes No

Employment

Occupation? _____

Employee Status? _____

Restrictions? _____

Retire Date? _____

Occupational Hazards? _____

Do you have Military Experience: _____ Yes No

What religion do you practice? _____

Social History/Habits

Do you use tobacco? _____ Yes No

What type? _____ How often? _____

For how long? _____ Ever tried to quit? _____ Yes No

Do you drink alcohol? _____ Yes No

Do you use illegal drugs? _____ Yes No

Do you consume caffeine? _____ Yes No

What type? _____ How often? _____

Do you exercise? _____ Yes No

What type? _____ How often? _____

Home Safety

Do you have animals in the home? Yes No

If yes – Birds Dogs Rodents Cats Reptile Other _____

Do you have smoke detectors? _____ Yes No

Do you have carbon monoxide detectors? _____ Yes No

Do you have firearms in you home? _____ Yes No

Radon in home? Yes No Treated Untested

Health Care Proxy

Power of Attorney: _____

Living Will: _____ DNR: _____

