Sacred Heart Medical Group

Medical History

Date:

Name: DOB: Patient #:

Sex: ☐ M ☐ F Living Will? ☐ Yes ☐ No Information given? ☐ Yes ☐ No PCP:

Allergies / Adverse Reactions

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list medication and reaction you had.

_____

_____

Immunizations (year received)

Tetanus / Diptheria:	Varicella:
Hepatitis B:	MMR:
BCG:	Other:

Hospitalization / Surgery

Year / Reason: _____ Year / Reason: _____

Year / Reason: _____ Year / Reason: _____

Family History

	Father	Mother	Paternal Granparent	Maternal Granparent	Brother #	Sister #		Father	Mother	Paternal Granparent	Maternal Granparent	Brother #	Sister #
Anemia							Heart Disease						
Asthma							High Blood Pressure						
Bleeding Disorder							Kidney Disease						
Cancer							Mental illness						
Diabetes							Osteoporosis						
Skin Disease							Stroke						
Epilepsy/Convulsions							Thyroid Disease						
Eye Disease													

Patient Medical History

Yes No

- ☐ ☐ Any illness or injury in the last 5 years?
- ☐ ☐ Head/Brain injuries, disorders or illnesses
- ☐ ☐ Seizures, epilepsy
  - ☐ medication _____
- ☐ ☐ Eye disorders or impaired vision (except corrective lenses)
- ☐ ☐ Ear disorders, loss of hearing or balance
- ☐ ☐ Heart disease or heart attack; other cardiovascular condition
  - ☐ medication _____
- ☐ ☐ Heart surgery (valve replacement/ bypass, angioplasty, pacemaker)
- ☐ ☐ High blood pressure
  - ☐ medication _____

Yes No

- ☐ ☐ Muscular disease
- ☐ ☐ Shortness of breath
- ☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis
- ☐ ☐ Kidney disease, dialysis, frequent urinary problems
- ☐ ☐ Liver disease
- ☐ ☐ Digestive problems
- ☐ ☐ Diabetes or elevated blood sugar controlled by:
  - ☐ diet
  - ☐ pills
  - ☐ insulin
- ☐ ☐ Nervous or psychiatric disorders, e.g., severe depression
  - ☐ medication _____
- ☐ ☐ Loss of, or altered consciousness

Yes No

- ☐ ☐ Fainting, dizziness
- ☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- ☐ ☐ Stroke or paralysis
- ☐ ☐ Missing or impaired hand, arm, foot, leg, finger, toe
- ☐ ☐ Spinal injury or disease
- ☐ ☐ Chronic low back pain
- ☐ ☐ Regular, frequent alcohol use
- ☐ ☐ Narcotic or habit forming drug use
- ☐ ☐ Joint or bone disorders/arthritis
- ☐ ☐ Hemorrhoids
- ☐ ☐ Tumor or cancer

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

_____

_____

_____

Work History

Have you been refused employment, been unable to hold a job, stay in school, been denied life insurance, or been refused military service because of any occupational, physical, or medical limitations? (If yes, state reason and give details) _____

_____

_____

_____

Have you ever applied for or received Workman's Compensation or other type of disability? (If yes, specify when, where, why, and how long.) _____

_____

_____

_____

Habits / Lifestyle

Tobacco use ☐ Yes ☐ No Type/amount _____ Illicit Drugs ☐ Yes ☐ No Type/amount _____

Alcohol ☐ Yes ☐ No Type/amount _____ Caffeine ☐ Yes ☐ No Type/amount _____

Other pertinent health information or religious limitations:

The above information is accurate and complete.

Name: _____ Signature: _____ Date: _____

Patient Reviewed and Verified as Correct (Write Initials and Date)								Physician Reviewed (Write Initials and Date)							

**Note: Any entries made after date that appears in upper right corner should be dated and initialed.*

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