MITMedical
Care for our community

Patient Health History

Patient name: _____
MRN: _____
DOB: _____
Date: _____

Reason for Visit/What do you want to talk about: _____

_____

_____

1. PATIENT HISTORY

Have you ever, or do you now have any of the following?

- ☐ anemia
- ☐ anorexia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ chicken pox
- ☐ eating problems
- ☐ depression
- ☐ diabetes
- ☐ epilepsy or seizures
- ☐ heart disease
- ☐ high/low blood pressure
- ☐ melanoma
- ☐ menstrual problems
- ☐ migraines
- ☐ sexually transmitted disease
- ☐ thyroid problems
- ☐ other, please list: _____

Please list all hospitalizations you have had (surgical, medical, psychiatric) and the year: _____

_____

_____

2. FAMILY HISTORY

If yes, check all that apply:

Breast Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Colon Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Diabetes	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Genetic Disorder	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Heart Disease	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
High Blood Pressure	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
High Cholesterol	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Other Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative

3. HEALTH RISK ASSESSMENT

Do you drink alcohol? ☐ no ☐ yes

If yes, # of drinks per week: _____

Do you smoke or use other forms of tobacco? ☐ no ☐ yes ☐ former

If former, quit date: _____

Have you ever used recreational/street drugs? ☐ no ☐ yes

Have you ever misused prescribed drugs? ☐ no ☐ yes

Do you exercise regularly? ☐ no ☐ yes

Are you satisfied with your eating habits? ☐ no ☐ yes

Over the past two weeks, how often have you had little interest or pleasure in doing things? Select one response.

☐ not at all ☐ several days ☐ more than half of the days ☐ nearly every day

Over the past two weeks, how often have you been down, depressed, or hopeless? Select one response.

☐ not at all ☐ several days ☐ more than half of the days ☐ nearly every day

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Are there any significant issues affecting family/significant others? ☐ no ☐ yes
If yes, please explain: _____
Are there any religious/cultural considerations regarding your care? ☐ no ☐ yes
If yes, please explain: _____
Do you have any questions about sexually transmitted diseases? ☐ no ☐ yes
Would you like to be tested for sexually transmitted diseases? ☐ no ☐ yes
Are you having any experiences on campus and/or at home that make you feel unsafe? ☐ no ☐ yes

4. ALLERGIES and IMMUNIZATIONS

Please complete section 4 A-B ***unless*** you have a Follow My Health account and you have reviewed and verified the accuracy of the information in your account.

For more information on Follow My Health, please visit medical.mit.edu/fmh

A. Allergies

Do you have any allergies to medications? ☐ no ☐ yes
If yes, please list medication(s) and reaction: _____

_____

_____

B. Immunizations

**Please bring any immunization information with you to your appointment.*

C. Medications

**Please bring any medication information with you to your appointment.*

5. LEARNING NEEDS ASSESSMENT

Do you have any of the following:
Learning disabilities? ☐ no ☐ yes
Visual limitations? ☐ no ☐ yes
Hearing limitations? ☐ no ☐ yes
If yes, please explain: _____

_____

_____

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6. REVIEW OF SYSTEMS

Are you currently experiencing any of the following....?

a. General

☐ Fatigue ☐ Trouble sleeping ☐ Weight changes ☐ Weakness ☐ Fever

☐ Pain, rated on a scale from 0 - 10 (0 = no pain, 10 = worst pain): _____

b. Functional assessment

Is your health limited in any of the following activities:

Work? ☐ no ☐ yes Moderate exercise? ☐ no ☐ yes
Daily chores? ☐ no ☐ yes Vigorous exercise? ☐ no ☐ yes

If yes, please explain: _____

c. Skin

☐ Rashes ☐ Itching ☐ Color changes ☐ Lumps ☐ Dryness ☐ Hair and nail changes

d. Head

☐ Headache ☐ Head injury

e. Ears

☐ Earache ☐ Tinnitus ☐ Drainage ☐ Decreased hearing

f. Eyes

☐ Vision ☐ Flashing lights ☐ Cataracts ☐ Glasses/contacts ☐ Blurry or double vision
☐ Pain ☐ Specks ☐ Redness ☐ Glaucoma ☐ Last eye exam: _____

g. Nose

☐ Itching ☐ Nosebleeds ☐ Stuffiness ☐ Discharge ☐ Hay fever ☐ Sinus pain

h. Throat/ Mouth

☐ Teeth ☐ Sore tongue ☐ Thrush ☐ Gums ☐ Dry mouth ☐ Non-healing sores
☐ Bleeding ☐ Sore throat ☐ Dentures ☐ Hoarseness ☐ Last dental exam: _____

i. Neck

☐ Lumps ☐ Pain ☐ Swollen glands ☐ Stiffness

j. Breasts

☐ Lumps ☐ Discharge ☐ Breastfeeding ☐ Pain

k. Respiratory

☐ Cough ☐ Coughing up blood ☐ Wheezing
☐ Mucus ☐ Shortness of breath ☐ Painful breathing

l. Cardiovascular

☐ Chest pain or discomfort ☐ Difficulty breathing lying down ☐ Tightness ☐ Palpitations
☐ Sudden awakening from sleep with shortness of breath ☐ Shortness of breath with activity ☐ Swelling

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m. Gastrointestinal

□ Diarrhea □ Constipation □ Change in appetite □ Nausea □ Yellow eyes or skin (jaundice) □ Change in bowel habits
□ Heartburn □ Rectal bleeding □ Swallowing difficulties

n. Urinary

□ Increased frequency □ Loss of control of urine □ Change in urinary strength
□ Urgency □ Burning or pain □ Blood in urine (hematuria)

o. Genital

Male

□ Hernia □ Pain with sex □ Genital sores □ Penile discharge □ Erectile dysfunction
□ STD's: _____ □ Scrotal masses or pain

Female

□ Pain with sex □ Hot flashes □ Vaginal itching or rash □ Vaginal dryness □ Vaginal discharge
□ STD's: _____ □ Last menstrual period: _____ □ Genital sores

p. Vascular

□ Calf pain with walking □ Leg cramping

q. Musculoskeletal

□ Back pain □ Stiffness □ Swelling of joints □ Trauma □ Redness of joints □ Muscle or joint pain

r. Neurologic

□ Dizziness □ Weakness □ Numbness □ Tremor □ Seizures □ Tingling □ Fainting

s. Hematologic

□ Ease of bruising □ Ease of bleeding

t. Endocrine

□ Heat or cold intolerance □ Frequent urination □ Sweating □ Thirst □ Change in appetite

u. Psychiatric

□ Stress □ Memory loss □ Nervousness □ Depression

The health and wellness of everyone in the MIT community is important to us at MIT Medical. We recommend the following:

- Condom use during sexual activity to reduce the risk of STDs and unintended pregnancy
- Use of automobile safety belts to reduce the risk of injury or death, which is the law in Massachusetts
- Use of helmets while bicycling, rollerblading, skate boarding, etc. to reduce the risk of injury
- Home smoke detectors to reduce the risk of injury or damage from a fire
- Use of sunscreen SPF 15 or higher for you and your children when in the outdoor sun

Patient Name (PRINT): _____ DOB: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____