Patient Health History

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
- [ ] depression
- [ ] epilepsy or seizures
- [ ] heart disease
- [ ] high/low blood pressure
- [ ] anemia
- [ ] arthritis
- [ ] asthma
- [ ] cancer
- [ ] chicken pox
- [ ] diabetes
- [ ] 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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Other Blood Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td></td>
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<tr>
<td>Colon Cancer</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>Genetic Disorder</td>
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<td></td>
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<tr>
<td>Heart Disease</td>
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<td></td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Other Cancer</td>
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</tr>
</tbody>
</table>

3. HEALTH RISK ASSESSMENT

Do you drink alcohol?
- [ ] no
- [ ] yes

If yes, # of drinks per week: __________

Yes, 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
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](http://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: __________________________________________
     - __________________________________________
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   ☐ Stiffness   ☐ 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   ☐ Mucus   ☐ Coughing up blood   ☐ Wheezing
   ☐ Difficulty breathing lying down   ☐ Shortness of breath   ☐ Painful breathing

l. Cardiovascular
   ☐ Chest pain or discomfort   ☐ Sudden awakening from sleep with shortness of breath
   ☐ Difficulty breathing lying down   ☐ Shortness of breath with activity
   ☐ Tightness   ☐ Palpitations   ☐ Swelling
m. Gastrointestinal
   - Diarrhea
   - Constipation
   - Heartburn
   - Rectal bleeding
   - Change in appetite
   - Nausea
   - Swallowing difficulties

n. Urinary
   - Increased frequency
   - Urgency
   - Loss of control of urine
   - Burning or pain
   - Change in urinary strength
   - 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: ____________