HIST

NMC health

PO Box 308 | Newton, KS 67114

Staff Only: Height: _____ Weight: _____ BP: _____

Visit Date: _____

Patient Medical History

Patient Name: _____ **DOB:** _____ **Age:** _____

Chief Complaint/Reason for Visit: _____

Preferred Pharmacy: _____

Name Address

Medications *Please list current medications.*			☐ **NO** current medications
Medication (include over-the-counter, vitamins, herbs)	**Strength (mg)**	**Quantity (ex. 2 tablets)**	**Times/day**

Allergies *Please list allergies and type of reaction.*	☐ **NO** KNOWN ALLERGIES

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

How many children do you have? _____

Household Members (relationship)**:** _____

Occupation: ☐ Working ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Grade (if student): _____ **(Prior) Occupation:** _____

Have you had a tobacco product in the last 30 days?

☐Yes (cigarettes/pipes/cigars) ☐Yes (smokeless/chewing) ☐ Yes (vaping) ☐No

Current tobacco status: ☐Never used ☐Current daily user ☐Current some days user ☐Former user

If you smoke, chew, or vape currently, would you like to quit? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes Quit: _____

If yes, how often? ☐ 0-2 drinks daily ☐3 or more drinks per day ☐ a few times a week

☐ a few times a month ☐ Holidays/Special Occasions

Do you use recreational drugs? ☐No ☐Yes: _____ ☐ Quit: _____

Do you exercise regularly? ☐No ☐Yes ***If yes, how many times per week?*** _____

Do you drink caffeine? ☐No ☐Yes ***If yes, how many cups per day?*** _____

Personal Medical Problems (Current and Prior) *Please circle all that apply.*		☐NO Medical Problems
Cardiovascular (Heart/Blood Vessels)	**Eyes**	**Mental Health**
Angina (Chest Pain)	Blindness	Anxiety
Atrial Fibrillation	Cataracts	Depression
Congenital Heart Defects	Glaucoma	**Muscular/Skeletal**
Congestive Heart Failure (CHF)	Macular Degeneration	Bone/Muscle Disorder: _____
Coronary Artery Disease	**GI (Stomach/Bowel/Liver)**	Osteoarthritis/Rheumatoid Arthritis
Heart Attack	Liver Disease / Cirrhosis	Osteoporosis
Heart Stents	Colon Polyps	**Neurological (Nerves/Brain)**
High Blood Pressure	GERD (Acid Reflux)	Migraine Headaches
High Cholesterol	Inflammatory Bowel Disease	Neuropathy
Pacemaker	Stomach or Duodenal Ulcers	Seizure Disorder / Epilepsy
Peripheral Artery Disease	**GU (Kidney/Bladder/Prostate)**	Stroke
Cancer	Kidney Disease / Dialysis	Tremor / Balance Disorder
Type:	**Hematologic (Blood)/Infectious**	**Respiratory (Lungs)**
Treatment & Year:	Anemia	Asthma
Endocrine	Bleeding Disorder	Bronchitis
Adrenal Disease	Blood Clots / DVT / PE	COPD / Emphysema
Diabetes - Type I / Type II	Hepatitis - Type:	Pneumonia
Thyroid Disease	MRSA Infection	Obstructive Sleep Apnea
Other Medical Problems/Major Illnesses/Hospitalizations:		

Prior Surgeries and Procedures *Please include year or age of occurrence.*	☐NO Prior Surgeries

Family History	☐ No Significant Family History	☐Adopted	☐Family History Unknown

***F**=Father, **M**=Mother, **S**=Sister, **B**=Brother, **PGM**=Paternal Grandmother, **PGF**=Paternal Grandfather, **PA**=Paternal Aunt, **PU**=Paternal Uncle, **MGM**=Maternal Grandmother, **MGF**=Maternal Grandfather, **MA**=Maternal Aunt, **MU**=Maternal Uncle, **C**=Child*

	Family Member(s) affected		**Family Member(s) affected**
Alcoholism		Diabetes	
Aneurysm		Drug Abuse	
Asthma		Heart Attack	
Arthritis		Heart Disease/CAD	
Bleeding Disorders		Heart Failure	
Blood Clots/DVT		High Blood Pressure	
Cancer - Breast		High Cholesterol	
Cancer - Colon		Inflammatory Bowel Disease	
Cancer - Lung		Kidney Disease/Dialysis	
Cancer - Melanoma		Liver Disease/Cirrhosis	
Cancer - Ovarian		Muscle/Nerve Disease	
Cancer - Thyroid		Rheumatoid Arthritis	
Cancer - Other:		Stroke	
Colon Polyps		Thyroid Disease	
COPD/Emphysema		Other:	
Dementia			