105 5th Avenue East
Scobey, MT 59263
406-487-2296

Your Medical History (Ages 17 & Above)

(please check all that apply)

Name:_____
Date of Birth:_____
Phone:_____

Today's Date:_____
Time:_____
Reviewed by:_____

- ☐ Alzheimer's Disease
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Cancer Other: _____
- ☐ Chronic Kidney Disease
- ☐ Cirrhosis of the Liver
- ☐ COPD or Emphysema
- ☐ Coronary Artery Disease (history of heart attack or stent)
- ☐ Colon Polyps
- ☐ CVA (Stroke)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus, Type I
- ☐ Diabetes Mellitus, Type II
- ☐ History of Blood Clot (DVT)
- ☐ GERD (acid reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Failure (that requires you to take medications such as water pills or heart pills)
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid (low thyroid)
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Malignant Melanoma
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pancreatitis, chronic
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease (in carotid (neck) arteries, leg arteries or aorta)
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ TIA (Transient Ischemic Attack)
- ☐ Tuberculosis
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency
- ☐ Currently Pregnant
- ☐ Other health issues or problems that require medication: _____

Your Family Medical History

Are you adopted? Yes/ No **If no, continue below**. If **yes**, continue only if you know birth family's medical history

	Father	Mother	Brother	Brother	Sister	Sister
List Family member 1st name in column						
If living, birth date, birth year or age if known						
If not living, age at death						
If not living, cause of death						
Put a check in the column of those that apply for family						
Asthma						
Breast Cancer						
Colon Cancer						
Coronary Artery Disease						
DVT/ Blood Clots						
Diabetes						
Heart Attack less than 50 years old						
High Cholesterol (Hyperlipidemia)						
High Blood Pressure (Hypertension)						
Heart Attack greater than 50 years old						
Ovarian Cancer						
Prostate Cancer						
Stroke						
Unknown Health Status						
Other health issues not listed (list)						

Do not file – shred after data entry

OVER ►

Your Social and Surgical History

Tobacco Use: (check any that apply)
☐ Current ☐ Never ☐ Quit, over 1 year
☐ Quit, Used within past year

What type: (check any that apply)
☐ Chewing Tobacco ☐ Cigarettes
☐ Cigars ☐ Pipe
☐ Other (list)_____

Amount Used per day: _____

Started at what age: _____
Stopped at what age:_____

Smoker (other than self) in the Household?
(check one) ☐ Yes ☐ No

Alcohol Use: (check any that apply)
☐ Current ☐ Never ☐ Past ☐ Recovering Alcoholic

What type: (check any that apply)
☐ Beer ☐ Wine ☐ Liquor
☐ Other (list)_____

Frequency:
☐ 1-2 drinks a day
☐ Greater than 2 drinks a day
☐ Infrequent or Seldom

Started at what age: _____
Stopped at what age:_____

Substance Abuse: (check any that apply)
☐ Current ☐ Never ☐ Past

What type: (check any that apply)

☐ Amphetamines	☐ LSD
☐ Cocaine	☐ Marijuana
☐ Ecstasy	☐ Methamphetamines
☐ Heroin	☐ Narcotics
☐ Inhalants/Glue/ Solvents	☐ PCP
	☐ Sedatives
☐ Ketamine	☐ Other:

Frequency: (check any that apply)
☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Started at what age: _____
Stopped at what age:_____

IV Drug Use: ☐ Current ☐ Never ☐ Past

Home/Environment: (check any that apply)
Lives with:
☐ Alone ☐ Children ☐ Father ☐ Mother
☐Siblings ☐ Significant Other ☐ Spouse
☐Other: _____

Living Situation: (check any that apply)
☐ Home/Independent
☐ Home with Assistance
☐ Assisted Living Facility
☐ Homeless/Shelter
☐ Group Home

Cultural Preferences: (check any that apply)
☐ No blood products
☐ Dietary restrictions
☐ Other _____

Home/Environment continued:
Pets in Home? (check one) ☐ Yes ☐ No

Type of pets: (check any that apply)
☐ Cat ☐ Bird
☐ Dog ☐ Other (list)_____

Does pet sleep in patient's room? (circle one) Yes/No

Employment/School:
☐ Employed ☐ Homemaker
☐ Retired ☐ Unemployed
☐ Student ☐ Disabled
☐ Other_____

What type of work: _____

Highest education:_____

Check box next to procedures or surgeries you have had. Circle which side or add other information. Please include the year if known.

Major Procedure/Surgery	Year
☐ None	
☐ Appendectomy (appendix removed)	_____
☐ Tonsillectomy (tonsils removed)	_____
☐ Adenoidectomy (adenoids removed)	_____
☐ Cholecystectomy (gall bladder removed)	_____
☐ Hysterectomy (uterus removed)	_____
☐ Ovaries removed–circle: Right Left Both	_____
☐ Prostate surgery	_____
☐ Cataract removal– circle: Right Left Both	_____
☐ Hernia repair – circle type (Inguinal-groin)	_____
(Umbilical-belly button) (other-_____)	_____
☐ Thyroidectomy- circle: Partial or Complete	_____
☐ Parathyroidectomy	_____
☐ Breast biopsy- circle: Right Left Both	_____
☐ Breast lumpectomy- circle:: Right Left Both	_____
☐ Mastectomy- circle: Right Left Both	_____
☐ Carotid endarterectomy (opens the neck artery) circle: Right Left Both	_____
☐ Coronary artery bypass (open heart)	_____
☐ Other Vein or Artery surgery-list details _____	_____
☐ Heart catheterization-circle below if applies: with: Stents or Angioplasty	_____
☐ Colonoscopy-list most recent	_____
☐ Upper endoscopy (scope into stomach)	_____
☐ Lumbar spine surgery (low back)	_____
☐ Cervical spine surgery (neck)	_____
☐ Total hip replacement - Right Left Both	_____
☐ Total knee replacement -Right Left Both	_____
☐ Other joint surgery- _____	_____
☐ Splenectomy (spleen removed)	_____
☐ Sinus surgery	_____
☐ Kidney stone removal	_____
☐ Bladder surgery	_____
☐ Cancer surgery, list location or details: _____	_____
☐ Other surgeries-list _____	_____
_____	_____