

Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental



Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-6823 – Dental

MAPLE/MORGAN STREET CLINIC/MACOUPIN COUNTY PUBLIC HEALTH CLINIC SITE

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____

Birth Date: _____ Sex: M / F / FTM / MTF Sexual Orientation: Lesbian/Gay Straight Bisexual Something Else Choose not to disclose

If the patient is a minor, please provide the parent's/guardian's name: _____

MEDICAL HISTORY

Please list all the medication you are currently taking including dose and directions:

Three horizontal lines for listing current medications.

Table with 3 columns of medical conditions and Y/N response options. Includes: High Blood Pressure, Low Blood Pressure, Pacemaker, Mitral Valve Prolapse, Heart Attack, Heart Surgery, Heart Murmur, Congenital Heart Defect, Anemia, Bleeding Problems, Bruise Easily, Sickle Cell Anemia, Hemophilia, Herpes/Fever Blisters, HIV+/AIDS, Hepatitis, Liver Disease, Kidney Problems, Diabetes, Ulcers/Colitis, Arthritis, Artificial Joints/Valves, Cancer, Chemotherapy, Radiation Treatment, Hospitalized for any reason, Epilepsy/Seizures, Migraines/Headaches, Fainting/Dizzy spells, Sinus Problems, Psychiatric Conditions, Difficulty Breathing, Coronary Artery Disease, Asthma, Emphysema, Stroke, and Tobacco use.

SCREENING TEST HISTORY

Have you had a colonoscopy? Y N If yes, where? _____ Date: _____
Women: Have you had a PAP smear? Y N If yes, where? _____ Date: _____
Have you had a mammogram? Y N If yes, where? _____ Date: _____

ALLERGIES

Are you allergic to any food or medication? Y N
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

SURGICAL HISTORY

Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____
Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____
Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____

FAMILY HISTORY

Please provide family history of diagnosis/disease for immediate family only.

Y	N	Diabetes	If yes, relation: _____	Y	N	Cancer Type: _____	If yes, relation: _____
Y	N	Heart Attack	If yes, relation: _____	Y	N	Stroke	If yes, relation: _____
Y	N	Low Blood Pressure	If yes, relation: _____	Y	N	Other: _____	If yes, relation: _____
Y	N	High Blood Pressure	If yes, relation: _____	Y	N	Other: _____	If yes, relation: _____

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

The information I have provided is correct to the best of my knowledge. I assume any risk to myself or my dependent and understand that I will ask if there are any questions regarding diagnosis or treatment. I understand it is my responsibility to inform this office of any changes in my/my dependent's medical status and/or medications being taken. I understand that I will be expected to update the information on this history form on an annual basis.

Patient/Parent's Signature: _____ **Date:** _____

Provider's Signature: _____ **Date:** _____

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