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

Macoupin County Public Health Department

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

MAPLE/MORGAN STREET MEDICAL 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:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Y	N	High Blood Pressure	Y	N	Herpes/Fever Blisters	Y	N	Epilepsy/Seizures
Y	N	Low Blood Pressure	Y	N	HIV+/AIDS	Y	N	Migraines/Headaches
Y	N	Pacemaker	Y	N	Hepatitis	Y	N	Fainting/Dizzy spells
Y	N	Mitral Valve Prolapse	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Psychiatric Conditions
Y	N	Heart Surgery	Y	N	Diabetes	Y	N	Difficulty Breathing
Y	N	Heart Murmur	Y	N	Ulcers/Colitis	Y	N	Coronary Artery Disease
Y	N	Congenital Heart Defect	Y	N	Arthritis	Y	N	Asthma
Y	N	Anemia	Y	N	Artificial Joints/Valves	Y	N	Emphysema
Y	N	Bleeding Problems	Y	N	Cancer	Y	N	Stroke
Y	N	Bruise Easily	Y	N	Chemotherapy	Other Conditions not listed:		
Y	N	Sickle Cell Anemia	Y	N	Radiation Treatment	_____		
Y	N	Hemophilia	Y	N	Hospitalized for any reason	_____		

Y N **Tobacco use?** If yes, how many packs a day? _____ How many years? _____

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: _____

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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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