MORGAN STREET MEDICAL CLINIC **1115 E. MORGAN ST. CARLINVILLE, IL 62626**

PATIENT HEALTH HISTORY

Last Name: ______________________________ First Name: ________________________ MI: ____ Today's Date: ____________________

Birth Date: ________________________ Sex: M / F / FTM / MTF

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: __________

For 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 medications: 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 provider 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: ____________________________________