UCS Healthcare
4908 Franklin Avenue, Des Moines, IA 50310
Phone: 515-280-4930 / Fax: 515-309-0686

Medical History Form

Office Notes

Legal Name: _____

Preferred Name: _____

Date: _____ **Work Phone**:_____

Please list **SPECIAL PROBLEMS** you would like evaluated today (#1 is most important):

1.

2.

3.

4.

MEDICATIONS: Prescription and non-prescription; include strength, how often, and how many pills taken. Also list all aspirin, vitamins, birth control, herbs, supplements, etc.

1)

2)

3)

4)

5)

6)

MEDICATION ALLERGIES:	**OTHER ALLERGIES**: (bees/foods/latex, etc.)
Type of reaction:	Type of reaction:

PAST MEDICAL HISTORY

List ongoing medical problems: (such as diabetes, heart, obesity, addictions, etc.)

1) 4)

2) 5)

3) 6)

Medical problems you have recovered from: (such as cancer, obesity, polio, etc.)

1) 3)

2) 4)

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Surgeries you have had: (including dates)

1) 4)

2) 5)

3) 6)

Hospitalizations and serious injuries

1) 3)

2) 4)

IMMUNIZATIONS / VACCINATIONS / SHOTS

Hepatitis B None 1 2 3 Date completed:	Hepatitis A None 1 2 3 Date completed:	HPV None 1 2 3 Date completed:
Tetanus Yes No Date:	Pertussis/Whooping cough Y N Date:	Pneumonia Yes No Date:
Chickenpox: Infection Shots Neither Date:	MMR (Measles, Mumps, Rubella) Yes No Date:	
Meningitis Yes No Date:	Influenza (flu) Yes No Dates:	
If you have ever had a test for Tuberculosis? results: Positive / Negative Date:		
Have you ever had a blood transfusion?	If yes: Dates:	

FAMILY HISTORY

Please check family members who have the following health problems:

	Father	Mother	Brother Sister	Child	Grand-parent	Other
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness (list type)						
Suicide						
Other health problems						

SOCIAL HISTORY

I identify as: heterosexual, gay, lesbian, bi-sexual, pan-sexual, polyamorous, _____

My birth sex: male, female, intersex, other_____	My legal sex: male female
I identify as: male female trans other_____	My preferred pronouns: he, she, _____

Single, Dating, Married, Long-Term Relationship(s), Widow/er, Divorced, Separated, _____

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Spouse's Name:	Spouse's Occupation:
Ages of Children:	# of People in Household:
Your Occupation:	Place Employed:
Level of Education:	Hobbies:
Recent Significant Changes in Your Life? Yes No	
Financial Hardships? Yes No	
Have Special Stresses in Your Life? Yes No	
I am **NOT** happy with (circle any that apply)	myself my health my work my weight my partner my life my_____

Many people face violence in their lives, but never receive help, as no one ever asks them about it. We are here to help if you are in need of it assistance.

Have you been in an abusive relationship?	Yes No
Does your partner ever hit you, hurt you, or threaten you in any way?	Yes No
Has your partner ever forced you to have sex when you didn't want to?	Yes No
Are you ever frightened of your partner?	Yes No
Has anyone ever hit you, hurt you, or threatened you in the past?	Yes No

CHEMICAL USE: ALCOHOL, CAFFEINE, OTHER

Have you ever used **tobacco products** regularly? Yes__ No__ if yes, continue:

Tobacco Product	Age Started Using	# of years used?	Amount each day	Still Use?

Circle the **beverages** you regularly consume and list the amount per WEEK:

Coffee/Tea: Pop/soda: what kind? # size/ounces diet or regular
Energy drinks: Beer: Wine: Hard liquor:

List the drugs and chemicals you've used, use right now, and how you've used them: (snort, shoot, swallow,…):

Drugs and Alcohol can sometimes affect your health and medications you take.

1. In the last year, how many times have you not remembered things that happened while you were drinking or using drugs?	5+ 3-4 1-2 0
2. In the last year, have you ever drank or used drugs more than you meant to?	Yes No
3. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Yes No
4. In the last year, have you drank or used non-prescription drugs to deal with your feelings, stress, or frustration?	Yes No
5. As a result of your drinking or drug use, did anything happen in the last year that you wish didn't happen?	Yes No
6. Have you been through any treatment programs?	Yes No

CURRENT HEALTH PRACTICES

Do you exercise regularly? yes / no Type of exercise and frequency:
How would you describe your diet?
Do you try to avoid: salt? Yes No fatty/fried foods? Yes No
How many meals do you eat per day? Snacks per day?
Amount and type of **dairy products** you consume per day:
How many meals do you eat out per week?

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If you are on a **special diet**, please explain:	
List any nutrition or diet concerns you would like help with:	
Are you happy with your weight? Yes No	
Do you have regular **Dental** exams? Y__ N__ How often do you brush____ floss___	
Do you wear your seatbelt: Always___ Sometimes___ Never___	
Circle the activities you participate in: Motorcycle Bicycle Ski/Snowboard Skateboard Do you wear a **helmet**? Always sometimes never N/A	
Have you been exposed to any **Toxic Substances**, such as asbestos, DES, radiation, chemicals? yes___ no___ if yes, please explain:	
Do you have a **smoke detector** at home? Y__N__ | When was it last checked?	
ORGAN DONATION: Are you an organ donor? Yes No Would you like to be? Yes No	
ADVANCED DIRECTIVES: Do you have an advanced directive or living will? Yes No Who has power of attorney or is your designated medical decision maker if you should become incapacitated?_____	

History Form				Office notes
<u>REVIEW OF SYSTEMS</u>: circle current concerns				
GENERAL				
Weight gain or loss	Increased Thirst or Urination		Night Sweats/Hot Flashes	
Always Hot or Cold	Dizziness	Fever	Fatigue, constant tiredness	
Swollen glands	Obesity	Overweight	Chronic Pain: _____	
Other				
EYE				
Glaucoma	Blurred or Double Vision- Ever		Glasses or Contact Lenses	
Cataracts	Brief Loss of Vision- Ever		Macular degeneration	
Discharge	Pain	Dry Itchy	Other:	
EAR, NOSE, AND THROAT				
Hearing Loss	Runny nose	Stuffy nose	Dental or gum problems	
Ear pain/drainage	Bloody nose	Broken nose	Trouble swallowing	
Ringing	Radiation to Head or Neck		Frequent sore throats	
Hayfever	Dentures	Voice change	Thyroid problems	
Other				
BREASTS/CHEST				
Lumps	Tenderness	Skin changes	Nipple drainage	
I do monthly self-breast exams		Last Mammogram_____		
Other				
LUNG				
Shortness Of Breath w/ Activity	COPD, Emphysema		Asthma	
Daily Phlegm Production	Coughing Up Blood		Wheezing	
Tuberculosis	Daily Cough		Smoker	
Other				
HEART				
Heart attack	High blood pressure		Chest Pain	
High cholesterol	Valve Problems		Heart Palpitations	
Difficulty Breathing Lying Flat	Leg Cramps While Walking		Irregular pulse	
Waking Up Short of Breath	Rheumatic fever		Ankle Swelling	
Other				

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GASTROINTESTINAL			
Change of Appetite	Heartburn	Abdominal Pain	Bloody or Black Stools
Difficulty Swallowing	Ulcers	Diverticulitis	Hemorrhoids
Diarrhea Constipation	Indigestion From Fatty Foods		Anal pain or fissure
Nausea/Vomiting	Crohn's disease or Ulcerative Colitis		Anal warts
Other			

NEUROLOGY				
Disabling Headaches, Migraines		Paralysis		Tremors
Peripheral Neuropathy		Memory Loss		Passing Out/Fainting
Seizures		Stroke, TIA		Dementia, Alzheimer's
Other				

MENTAL HEALTH				
Depression	Anxiety	Panic Attacks	Bipolar	Schizophrenia, Hallucinations
Past sexual assault, severe trauma		Suicide attempts		Eating disorder
Chemical dependency/abuse		Insomnia		Post traumatic stress disorder
Other				

MUSCULOSKELETAL		
Frequent Neck or Back Pain	Muscle Pain or problems	Disabling Night Leg Cramps
Joint Problems, Arthritis	Use a Brace or a Splint	Osteoporosis
History of Broken Bones	Joint Replacement	Fibromyalgia
Other		

SKIN				
Eczema	Acne	Warts	Psoriasis	Changing moles, spots
Excessive dryness		Other:		

MISCELLANEOUS			
Diabetes	Osteoporosis	High Cholesterol	Thyroid: low or overactive
Sleep apnea	Insomnia	Cancer	Restless legs, cramps
Anemia	Blood problem	Other	

GENITAL, URINARY, KIDNEY			
Urinary Tract Infections	Difficult or Painful Urination		Sores in the Genital Area
Kidney or Bladder Stones	Blood in Urine	Urination More Than Once a Night	
History of Four or More Sex Partners		Sexual Intercourse Before 18 years old	

I am currently sexually active No__ Yes__ with ___# partners

My current sexual partner(s) is/are male, female, transman, transwoman, _____

My past sexual partners have included male, female, transman, transwoman, _____

Method of Birth Control: I would like more information

I follow safer sex guidelines: Always Sometimes Never I would like to review them

I am satisfied I am not satisfied with my current sexual relationship(s)

My partner has a sexual health issue I would like to discuss:_____

What STDs/sexually transmitted infections have you had? None

What/when?

Other:

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PENIS				
Pain or Lump in Testicles/Scrotum		Do you do Self Testicular Exam? Yes No		
Hernia	Prostate problems	Painful intercourse		
Difficulty getting an erection		Inability to ejaculate (unable to cum)		
Premature ejaculation (too quick)		Other		
VAGINA				
Age of first Period:		Days between Menstrual Periods: _____		
Date Last Menstrual Period: _____		Length of Menstrual Periods: _____ days		
Heavy flow	Painful cramps	Irregular Periods	Changing pattern	
# Pregnancies:_____, live births_____, stillbirths____, abortions____, miscarriages____				
Painful sex	Dry vagina	Orgasm difficulty	Vaginal Discharge/Itching/Odor	
Dates of Most recent Pap Smears: _____, _____, _____				
History of Abnormal Pap Smear: Y N		Abnormal Pap treatment:		
Other				

PLEASE LIST ALL YOUR OTHER DOCTORS, SPECIALISTS, THERAPISTS, AND HEALTHCARE PROVIDERS AND SPECIFY IN WHAT AREAS THEY ASSIST YOU: (example: Dr. BG Heart, Cardiology**)**

1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	

To the best of my knowledge, this is an accurate statement of my health:

Signature:_____ Date: _____