Medical History Form

Patient Name__________________ **Date**____________

Past Medical History

Do you have any **allergies** to medicines? □no □yes ________ reaction___________

Have you had any overnight **hospital** stay? □no □yes

If yes, What for? _______________ year_________

_______________ year_________

_______________ year_________

Have you had any **surgeries**? □no □yes

If yes, What for? _______________ year_________

_______________ year_________

_______________ year_________

Please check if you have ever had or been told you have any of the following:

□ asthma □ diabetes □ high blood pressure □ heart disease □ hepatitis □ depression □ anxiety

□ other mental health issues □ eating disorder □ HIV □ kidney problems □ high cholesterol

□ other________________________ □ **none of the above**

Preventive Care

Please list your most recent:

	Never	Date of test/vaccine	Location/clinic	Result (normal or not)
colonoscopy				
Tetanus vaccine				
Pap (women)				
Mammogram(women)				

Family Health History

Please list any members of your biological family (blood relatives) who have had any of the following diseases (example: mother, uncle, grandfather)

Condition	**Relative**	**Provider notes**
Breast cancer		
Colon/intestinal cancer		
Prostate cancer		
Cancer - other		
Diabetes		
High Blood Pressure		
Stroke		
Blood clots		
Early Heart disease/heart attack (men<55 women <65)		
Elevated Cholesterol		
Depression		
Other mental health illnesses		
Chemical dependency (alcohol or drug addiction)		
Bipolar disorder		
Other:		

□ none of the above □ Family history not available

Social History

Who do you live with?______________________________

Do you have children? □yes □no

Name of child	Date of Birth	comments

Dakota Child and Family Care
2530 Horizon Drive, Burnsville, MN 55337

Updated by provider (signature) ___________________ Date: ______________