SWEDISH

Community Health Medical Home

Adult Medical History

Name:	Date of Birth:
	Today's Date:

Medical History

Please make a checkmark next to any conditions you have now or have had in the past.

Constitutional	
	Unexplained weight loss of more than 10 pounds in the last 6 months
Heart and Blood Vessels	
	High blood pressure
	High cholesterol
	A heart attack
	Heart failure
	Irregular heart beat
	Other:
Lungs	
	Asthma
	Chronic bronchitis or emphysema/COPD
	Other:
Digestion	
	Acid reflux/heartburn
	Stomach ulcer
	Other:
Kidneys or Bladder	
	Kidney stones
	Blood in your urine
	Frequent bladder infections
	Other:

Metabolism	
	Diabetes
	Thyroid problems
	Other:
Nerves and Brain	
	Seizures
	Stroke
	Other:
Muscles, Joints and Bones	
	Neck/back problems
	Arthritis (joint pain)
	Other:
Social and Mental Health	
	Depression
	Anxiety
	Alcohol or substance abuse
	Sleep problems
	Other:
Infectious Diseases	
	Hepatitis
	HIV
	Other:
Cancer	
	Type:

Surgical History

Type of Surgery	Year	Surgeon

Health Maintenance

When was the last time you had colon cancer screening? What type: ☐ stool cards ☐ sigmoidoscopy ☐ colonoscopy What was the result of the screening? ☐ normal ☐ abnormal
How many times per week do you exercise? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 How many minutes do you exercise each time? ☐ 10-15 ☐ 15-30 ☐ 30-45 ☐ > 45 minutes Types of activities:
How would you describe your diet? *(check all that apply)* ☐ vegetarian ☐ vegan ☐ red meat (primarily) ☐ fish/poultry (primarily) ☐ low carbohydrate ☐ low fat ☐ low salt ☐ gluten free ☐ lactose free
Do you see an **alternative health-care provider** (chiropractor, naturopath, acupuncturist)? ☐ Yes ☐ No

Allergies

Medication or Other Item	Reaction (e.g., rash, swelling, difficulty breathing)

Medications

Medication (including vitamins, herbs, supplements)	Dose	Frequency	Prescribed by

Family Medical History

Please make a checkmark next to any conditions that an immediate family member has or had (parents, grandparents, siblings):

Condition		Who
	Diabetes	
	Heart attack or heart disease	
	Cancer (*what type?)*	
	Mental health problems	
	Other conditions *(please list:)*	

For Women Only

When was the start date of your last menstrual period?	
Are your periods: ☐ regular ☐ irregular ☐ heavy ☐ accompanied by severe cramping	
Do you use birth control? ☐ No ☐ Yes	If Yes, what type:
When was your last PAP smear?	
Have you ever had an abnormal PAP? ☐ No ☐ Yes	If Yes, when?
When was your last mammogram?	☐ Normal ☐ Abnormal
How many times have you been pregnant?	
Number of deliveries?	Number of miscarriages?
Did you have complications during pregnancy or delivery? ☐ No ☐ Yes	
Are you post-menopausal? ☐ No ☐ Yes	If Yes, menopause at age:

Social History

Relationship status: ☐ married/partnered ☐ single ☐ separated ☐ divorced ☐ widowed	
Do you have any children? ☐ Yes ☐ No If yes, how many?	
Who lives at home with you?	
Name:	Relationship:
Highest education level:	Occupation:
Employment: ☐ full-time ☐ part-time ☐ unemployed ☐ retired ☐ homemaker ☐ in school	
How satisfied are you with your current job? ☐ very satisfied ☐ neutral ☐ dissatisfied	
Sexual partner(s): ☐ men ☐ women	
Do you have a living will? ☐ Yes ☐ No	

Please answer the following questions by placing a checkmark under either the "yes" or "no" column.

	YES	NO
Do you currently smoke? If so, how many packs a day? ☐ ¼ ☐ ½ ☐ 1 ☐ 2 ☐ 3 or more		
Are you a former smoker? If so, what year did you quit? _____ How many years did you smoke? _____ How many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 2 ☐ 3 or more		
Do you drink alcohol? If so, how many drinks per day? _____ . Per week ?_____		
Do you binge drink?		
In the past 10 years, have you ever tried recreational drugs? If so, what type? ☐ marijuana ☐ cocaine ☐ heroin ☐ methamphetamines ☐ prescription narcotics ☐ Other (*please list:)*		
Have you ever been emotionally, sexually and/or physically abused?		
Do you currently feel threatened in your environment?		
Do you practice safe sex (i.e., using condoms)?		
Are you currently sexually active?		
Do you have more than one sexual partner?		
Has there ever been a period of time when you did not sleep for several days or were so hyper that you got into trouble?		
During the past 2 weeks, have you felt down, depressed or hopeless?		
During the past 2 weeks, have you had little interest or pleasure in doing things?		
During the past month, have you often felt so anxious that you couldn't stand it?		
During the past month, have you had repeated, disturbing flashbacks of a past stressful experience?		
Have you ever seriously considered or attempted suicide?		
Do you have a suicide plan at the moment?		

We would like to ask you a few more questions to better understand your health care needs. Please circle the answer that applies to you.

How do you rate your health?	Very unhealthy	Unhealthy	Average health	Healthy	Very healthy
Over the last year, how satisfied have you been with your health care?	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
In the past year, how many times have you been treated in an Emergency Room?	5 or more		2-4	0 or 1	
In the past year, how many times have you been hospitalized?	3 or more		2	0 or 1	

We would like to know about your experience with past medical care. Thank you so much.

I had one person that I thought of as my personal doctor or nurse.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It was easy for me to get medical care when I needed it.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Most of the time, when I visited my doctor's office, it was well-organized, efficient, and did not waste my time.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information given to me about health problems was very good.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am confident that I can manage and control most of my health problems.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

Other comments or suggestions:

SWEDISH

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