Caring Partner Medical Clinic Confidential Medical History

Name: _____

Past Medical History

Please indicate if you have had any of the following.

Condition	Yes	Condition	Yes
Asthma/COPD		High cholesterol or triglycerides	
Blood Clot		Hay Fever	
Anxiety, depression or mental illness		Stroke or TIA	
Blood problems (abnormal bleeding, anemia, high or low white count)		Treatment for alcohol and/or drug abuse	
Diabetes		Tuberculosis or positive tuberculin skin test	
Growth removed from the colon or rectum (ployp or tumor)		Thyroid Disorder	
High blood pressure		Heart Disease	

Past Surgical History

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (✓) in the appropriate boxes. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	No problem	Medical Problem	Surgery	Years of Surgery	Describe
Eyes (cataracts, glaucoma)					
Ears, nose, sinuses, or tonsils					
Thyroid or parathyroid glands					
Ear valves or abnormal heart rhythm					
Coronary (heart) arteries (angina)					
Arteries (aorta, arteries to head, arms, legs)					
Veins or blood clots n the veins					
Lungs					
Esophagus or stomach (ulcer)					
Bowel (small & large intestine)					
Appendix					
Liver or gallbladder (including hepatitis)					
Hernia					
Kidneys or bladder					
Bones, joints or muscles					
Back, neck or spine					
Skin					
Breasts					
Females (uterus, tubes, ovaries)					
Males: prostate, penis, testes, vasectomy					
Other: Describe					

Family History

Are you adopted? ❒ Yes If known, complete the following information about your blood relatives (include children). Exclude adoptive parents, siblings and adopted children.

❒ No Complete the following information about your blood relatives. Exclude adoptive siblings and adopted children.

Father ❒Alive (Age ____) ❒Deceased (Age ____) ❒Unknown Cause of Death _____
Mother ❒Alive (Age ____) ❒Deceased (Age ____) ❒Unknown Cause of Death _____

	Number Alive	Approximate Age(s)	Number Deceased	Approx Age(s) at Death	Cause of Death	Unknown
Brothers						
Sisters						
Sons						
Daughters						

Place a checkmark (✓) in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Check "NONE" if you are not aware of any relative having the illness/condition.

Illness/Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children	NONE	Describe
Asthma, Bronchitis or Emphysema										
Coronary Heart Disease										
High Blood Pressure										
Heart Attack/Surgery										
Stroke										
Blood Clot										
Epilepsy/Seizures										
Thyroid Disorder										
Anemia										
Migraines										
Allergies										
Colon Cancer										
Ovarian Cancer										
Breast Cancer										
Prostate Cancer										
Cervical Cancer										
Diabetes										
High Cholesterol										
Depression										
Anxiety										
Dementia										