

Note: This is a confidential record of your medical history and will be kept within Wheaton Franciscan Healthcare. Information contained here will not be released to any person except when you have authorized us to do so.

Wheaton Franciscan Healthcare Patient History

Date Received
(for office use only)

Date _____
 Patient's Name _____
 Who completed this form? Patient Spouse Other (specify) _____
 Address _____ Phone No. _____ Work Phone No. _____
 Sex: Male Female Date of Birth: (month/day/year) _____ Referred by _____

ALLERGIES:

	Allergy	Reaction
Drug		
Food		
Environment		
Latex		

Potential Latex Allergy – Sensitive to: Nuts Avocados Kiwi Balloons

MEDICATION:

DISPOSITION:

Prescription/Non-prescription/ Over-the-Counter Medication	Dose & Frequency Prescribed	Time Last Dose

MED / SURG 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 box(es). 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. For Covenant Clinic patients see Family History Form.

- | | No Problem | Medical Problem | Family History | Surgery | Year(s) of Surgery | Seen By Specialist | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------|--------------------|-------|
| 1. Head (injuries, loss of consciousness, concussion, headaches, migraines, epilepsy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 2. Eyes (cataracts, glaucoma, impaired vision) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 3. Ears (impaired hearing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 4. Nose , sinuses (asthma, hay fever) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 5. Mouth , throat, tonsils | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 6. Thyroid or parathyroid glands (goiter) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 7. Heart valves or abnormal heart rhythm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 8. Cardiac (heart attack, angina, high blood pressure, high cholesterol or triglycerides) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 9. Arteries/Veins (aorta, arteries to head, arms, legs, blood disease, blood clots) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 10. Lungs (tuberculosis [TB], pneumonia, pleurisy, chronic cough, shortness of breath) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 11. Esophagus or stomach (ulcer) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 12. Bowel (small or larger intestine, colitis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 13. Appendix | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |
| 14. Rectum (hemorrhoids, rectal bleeding, change in bowel habits) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Y / N | _____ |

Patient's Name _____

	No Problem	Medical Problem	Family History	Surgery	Year(s) of Surgery	Seen By Specialist	Describe
15. Liver or gallbladder (including hepatitis, liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
16. Pancreas (diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
17. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
18. Lymph nodes or spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
19. Kidneys or bladder (stones, abnormal urine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
20. Back, neck or spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
21. Bones, joints or muscles (arthritis, bursitis, osteoporosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
22. Brain (anxiety, depression, psychiatric illness, seizures/epilepsy, stroke/TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
23. Skin (hives, eczema, jaundice, frequent sores)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
24. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
25. Males: prostate, testes, vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
26. Female: Uterus, tubes, ovaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
27. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
28. Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
29. Genetic or inherited disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___	Y / N	_____
30. Other							_____

MENSTRUAL HISTORY

Age at Onset _____ Age Stopped _____ Usual Duration of Periods _____ Days
 Is your menstrual period: Heavy Medium Light Do you have: Tension Depression Hot Flashes Cramps Pain

PREGNANCY HISTORY

How many? Live Births _____ Abortions/Miscarriages _____ Stillbirths _____ Premature Births _____
 Did you deliver vaginally or cesarean section? _____
 Do you use birth control? Yes No If yes, what kind and for how long? _____

SOCIAL HISTORY

Education: High School Graduate Yes No Post High School Graduate Yes No Number of Years: 1 2 3 4 _____
 Occupation: Current employment status: Retired Unemployed Homemaker Disabled
 Employed-Current Occupation _____
 Abuse: Have you ever been physically, sexually, or emotionally abused? Yes No

Have you used any of the following substances?	Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long?	If stopped, when?	Family History
	Caffeine: coffee, tea, soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Alcohol - beer, wine, liquor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Street drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

Marital Status: Are you currently single married? age _____ divorced? year _____
 widowed? year _____ cause of death _____

Current Spouse Info: If alive, current employment status: Retired Unemployed Homemaker Employed-current occupation(s) _____

Nutritional Status: Do you have a specific nutrition plan? Yes No low fat vegetarian low calorie Diabetic Other _____
 Do you exercise? Yes No Type and frequency _____

Culture/Religion: Do you have any cultural or religious beliefs that will affect your health care? Yes No → _____

Advanced Directives: Do you have a living will or durable power of attorney? Yes No

Reviewed by Medical Staff _____ Date _____
 Updated by _____ Date _____
 Updated by _____ Date _____

Wheaton Franciscan Healthcare Family History

Date _____

Patient's Name _____

Are you adopted? Yes No

Has anyone in the family had any of the following (if so, mark box with an X. Follow directions below for family tree.

Endocrine Problems

- Thyroid, Goiter
- Parathyroid Disease
- Diabetes
- Obesity
- Liver Problems
- Other _____

Heart Disease / Vascular

- High Blood Pressure
- Stroke/TIA
- Bad Heart Valves
- Coronary Bypass
- Elevated Cholesterol/Triglycerides ...
- Aortic Aneurysm
- Other _____

Eye Problems

- Cataracts
- Glaucoma
- Blindness
- Other _____

Respiratory Problems

- Tuberculosis
- Emphysema
- Asthma
- Hay Fever
- Allergy
- Hives
- Cystic Fibrosis
- Other _____

Psychiatric Problems

- Anxiety / Mood Disorder
- Depression
- Drug or Alcohol Abuse
- Chemical Imbalance / Bipolar
- Other _____

Other

- Multiple Sclerosis
- Arthritis (Rheumatoid/Osteo)
- Osteoporosis
- Gout
- Myeloma
- Blood Disease/Sickle Cell
- Anemia
- Skin Disorders
- Eczema
- Leg Amputation
- Carotid/Artery Problems
- Genetic Disorder
- Anesthetic Complications
- Other _____

Cancer

- _____
- _____
- _____
- _____
- _____
- Other _____

Brain Problems

- Alzheimer's
- Seizures/Epilepsy
- Headaches
- Parkinson's
- Neuromuscular Disease
- Other _____

FAMILY TREE: List age or age at death and illnesses from above for each family member.

Mother's Mother

Mother's Father

Father's Mother

Father's Father

Mother

Father

Siblings

Children

Reviewed by _____

Date _____

Updated by _____

Date _____

Updated by _____

Date _____