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Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Name_____ Today's date_____
Preferred Pronoun_____ Date of Birth_____
Primary Care Provider: _____ Clinic or Office: _____
Last Seen: _____(month) / _____ (year)

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Chronic diarrhea	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
If yes, what age?_____			Stroke	☐ Yes	☐ No
Emotional problems	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Gonorrhea/Chlamydia	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Acid Reflux (Heartburn)	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Other Autoimmune or immunosuppressive condition	☐ Yes	☐ No

If yes to any of the above, please explain:_____
_____
_____
_____

When was your last Tetanus shot given? _____

(more on next page)

2. Family Medical History

☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:	Living/Deceased:
Alcoholism	☐ Yes	☐ No		
Anemia	☐ Yes	☐ No		
Arthritis	☐ Yes	☐ No		
Bowel/Colon Cancer	☐ Yes	☐ No		
Breast Cancer	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Heart Disease/Angina	☐ Yes	☐ No		
Hepatitis	☐ Yes	☐ No		
High Blood Pressure	☐ Yes	☐ No		
High Cholesterol	☐ Yes	☐ No		
Kidney Disease	☐ Yes	☐ No		
Strokes	☐ Yes	☐ No		
Thyroid Disorder	☐ Yes	☐ No		
Tuberculosis	☐ Yes	☐ No		
Mental Illness	☐ Yes	☐ No		
Other_____	☐ Yes	☐ No		

3. Personal Habits & Risk Factors

Tobacco Use

Cigarettes: ☐ Never ☐ Quit-Date_____ ☐ Current Smoker-Packs per day__# of years_____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If yes, average # of drinks per week____

If no, have you in the past? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills? ☐ Yes ☐ No

Have you ever used needles? ☐ Yes ☐ No

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

Do you use protection:

Condoms?	☐ Sometimes	☐ Always	☐ Never
PrEP?	☐ Sometimes	☐ Always	☐ Never
Birth Control?	☐ Sometimes	☐ Always	☐ Never

Other _____

Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No

If yes, please include_____

When were you last tested? _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercises?_____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

4. TB Risk Assessment

Were you born in or have you lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean, or the Middle East for more than one month?	☐ Yes ☐ No
In the last 2 years, have you lived or spent time with someone who has been sick with TB?	☐ Yes ☐ No
Have members of your household come to the United States from another country?	☐ Yes ☐ No
If yes, name of country: _____	
Have you ever been to jail or prison?	☐ Yes ☐ No
Have you ever had an organ transplant?	☐ Yes ☐ No
Have you ever worked anywhere that processed TB samples?	☐ Yes ☐ No
Have you ever been told you have an abnormal chest X-Ray?	☐ Yes ☐ No
Have you had any symptoms of TB (couch, fever, night sweats, loss of appetite, weight loss, or fatige)?	☐ Yes ☐ No
If yes, name symptom and when: _____	
Have you been homeless (Including living in a shelter) in the last 30 days?	☐ Yes ☐ No
Do you perform work that involves sexual contact?	☐ Yes ☐ No
Have you been sexually assaulted in the last 30 days?	☐ Yes ☐ No
Have you had a needle stick injury since you were last tested for any infectious disease?	☐ Yes ☐ No

5. Medications

Please list all your current medications, including medications/supplements not needing a prescription:

Medication	Dose and Directions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(more on next page)

6. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect

7. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation

8. If Applicable

Total # of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions_____

Age at start of menstrual period _____

Date most recent menstruation began _____ Usual length of menstrual period _____days

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, give date and describe_____

Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when_____

Are you or have you experienced menopause? ☐ Yes ☐ No

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods	☐ Yes	☐ No
Bleeding between periods or after menopause	☐ Yes	☐ No
Vaginal discharge, pain or itching	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Pain or lumps in breasts	☐ Yes	☐ No

(Next page for providers only)

For Providers only:

Need for Medical Follow up:
As a result of reports of sudden unexplainable behavior change, rapid or major weight loss or gain, reports of compulsive behavior or addiction history, acute signs or symptoms of substance withdrawal, or reports of injected intravenous drugs currently or within the last 3-6 months), client has been referred to:

☐ Primary Care Provider
☐ Onsite medical provider
☐ Medical Director waived referral for physical examination and lab testing due to documentation that client has received these services in the past 90 days

Pregnancy Risk
☐ Referral made for testing
☐ Referral made for prenatal care (within 14 days)

Withdrawal from Substance Use
☐ Symptoms of withdrawal resulted in staff consulting with onsite medical provider within 24 hours

Infectious Disease
☐ Client's identified at risk for infectious disease
If checked, then…
☐ Client has been referred to onsite medical provider for further examination, risk assessment, lab testing.
☐ Client has been referred to other care provider: _____

As a result of any of the following in the last 30 days:

- Intravenous drug use
- Homelessness / Living on the street / Living in a shelter
- Release from Jail or Prison
- Coming into contact with another person's blood
- Needle stick injury
- Sexual assault
- High risk sexual behavior
- Work that involves sexual contact

MedicalHistory_WPCTS
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