GRETNA MEDICAL CENTER
PATIENT MEDICAL HISTORY

Patient's Name: ______________________ Today's Date: ______________________

Social Security Number: ______________________ Date of Birth: ______________________

Past Medical History

Previous Physician's Name: ______________________ Date of last exam: ______________________

Have you ever been hospitalized? ☐ Yes ☐ No If yes, what for? ______________________

Have you ever been tested for hepatitis A, B or C? ☐ Yes ☐ No Which hepatitis virus? ______________________

Have you been vaccinated for hepatitis B? ☐ Yes ☐ No If yes, date vaccine series completed ____________

Have you been vaccinated for hepatitis A? ☐ Yes ☐ No If yes, date vaccine series completed ____________

Last Tuberculosis (TB) Screening? ______________________ Result of TB screening: ☐ Positive ☐ Negative

If positive TB screen, date of last chest x-ray: ____________ Result of chest x-ray: ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: ______________________

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐ Heart disease / Murmur / Angina	☐ Shortness of breath	☐ Eye disorder / Glaucoma	☐ Diabetes
☐ High Cholesterol	☐ Asthma	☐ Seizures	☐ Kidney / Bladder problems
☐ High blood pressure	☐ Lung problems / cough	☐ Stroke	☐ Liver problems / Hepatitis
☐ Low blood pressure	☐ Sinus problems	☐ Headaches / Migraines	☐ Arthritis
☐ Heartburn (reflux)	☐ Seasonal allergies	☐ Neurological problems	☐ Cancer
☐ Anemia or blood problems	☐ Tonsillitis	☐ Depression / Anxiety	☐ Ulcers/colitis
☐ Swollen ankles	☐ Ear problems	☐ Psychiatric care	☐ Thyroid problems

Please describe any current or past medical treatment not listed above

____

____

Please list your past surgeries

____

____

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list: ____

Medications:

Please list: ____

____

Immunizations (check one): up to date_____ delayed_____ Don't know_____ Chose not to immunize_____

Social and Preventive History

Smoking Status:

☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown

☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? ______________

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? ______________

Do you exercise daily/weekly? ☐ Yes ☐ No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Siblings	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member?
Asthma	
Anemia or Blood disease	
Cancer	
Diabetes	
Glaucoma	
Heart disease	
High blood pressure	
HIV disease / AIDS	
Mental Illness / Depression	
Stroke	
Other serious illness	

Females: Gynecological History

How many times have you been pregnant? ______________ Date of last Pap Smear: ______________

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis: ______________ Follow up: ______________

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: ______________

Date of last mammogram: ______________ Mammogram results: ______________

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy results: ______________

Children: Birth History

Pregnancy or birth complications? ______________ Full term or preterm? ______________ Twins? ______________

How many weeks/months? ______________ Type of Delivery (vaginal/caesarean) ______________ Birth weight ______________

Breast fed or bottle fed (circle one), until what age? ______________ Birth length ______________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ______________ **Date** ______________