Mercy Clinics, Inc.
A member of Mercy Medical Center–Des Moines

Today's Date _____
Updated Dates _____

PATIENT MEDICAL HISTORY

Name: _____ **Birthdate:**_____
Last First Middle (Month/Day/Year)

PERSONAL HISTORY OF ILLNESS: (Check any illness, past or present)

☐ Head Injury	☐ADHD/ADD	☐Thyroid Disease	☐Liver Disease	☐ Joint Trouble
☐Headache	☐Alcohol abuse	☐Heart Disease	☐Kidney Disease	☐High Cholesterol
☐Epilepsy (seizure)	☐ Eye Disease	☐High Blood Pressure	☐Anemia	
☐Bipolar	☐Asthma	☐Lung Disease	☐Broken Bones	
☐Anxiety	☐Diabetes	☐Pneumonia	☐Substance/Prescription drug/Narcotic Abuse	
☐Depression	☐Cancer	☐Stomach Ulcers	☐Skin Trouble/Infections	
			☐Sexually Transmitted Infections	

☐Other_____
_____

SURGERIES AND HOSPITALIZATIONS

Year	Surgery or reason for hospitalization	Year	Surgery or reason for hospitalization
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If yes, what? _____
Any other allergies (latex, rubber, etc.)?_____

FAMILY HISTORY

Is there any history of the following diseases in your family? If yes, indicate which relative.

DISEASE	WHICH RELATIVE	DISEASE	WHICH RELATIVE
Cancer	_____	Heart Disease	_____
Stroke	_____	High Blood Pressure	_____
Diabetes	_____	Tobacco/Alcohol Abuse	_____
Asthma/Lung Disease	_____	Reaction to Anesthesia	_____
Depression/Mental Illness	_____	Other	_____

SOCIAL HISTORY

☐ Married ☐ Widowed ☐ Single ☐Divorced ☐Partnered Occupation: _____

Are you in a safe environment: ☐ Yes ☐ No

Children: ☐ No ☐ Yes – How many _____

Caffeine use: ☐ No ☐ Yes – How much _____ (coffee, tea, cola)

Exercise: ☐ No ☐ Yes – How often _____

Drug Use: ☐ No ☐ Yes – How often _____ (Marijuana, LSD, Speed, Heroin, Methamphetamine, Narcotics, etc.)

Alcohol use: ☐ No ☐ Yes – How much _____ (including beer and wine)

Tobacco use: ☐ No If quit, how long did you smoke? _____ ☐ Yes – How much _____ Year began ____

Do you have a Living Will/Advance Directives/Power of Attorney for Health Care Decisions? ☐ Yes ☐ No
Do we have a copy? ☐ Yes ☐ No

PHYSICIAN USE ONLY

Date	Event List

Date	Chronic Problem List