Midwest Immunology Clinic
Patient Medical History Form (ADULT)

Patients who have completed and returned this form will have priority if on our cancellation list.

Appointment Dates:_____

Patient Name:_____ **DOB:**_____ **Age:**_____

PRIMARY CARE MD:_____

Location/Phone: _____

REFERRING MD: _____

Location/Phone:_____

Main reason for today's visit:_____

Current Pharmacy Name/Location:_____

MEDICAL HISTORY

Diagnosis	Date Diagnosed	Care Provider	**Medications/Therapies For This Diagnosis** (name/dosing/prescriber)

SURGICAL HISTORY

Date	Surgery	Provider/Hospital

HOSPITALIZATIONS (not including surgeries listed above)

Date	Reason	Provider/Hospital

OTHER MEDICATIONS (please include vitamins, herbal supplements, and over-the-counter medications)

Medication	Dosage	Prescribing MD/NP	Medication	Dosage	Prescribing MD/NP

Date of last bone density (DEXA) scan: _____ Have you had an abnormal DEXA scan? Yes No
If yes, when/what was done? _____

Date of last pulmonary function test (PFTs): _____ Have you had an abnormal PFTs? Yes No
If yes, when/what was done? _____

Have you ever had a TB skin test (PPD/Mantoux)? Yes No
If yes, date: _____ Result: _____

FEDERAL RACE/ETHNICITY INFORMATION

In compliance with Federal regulations, Midwest Immunology Clinic collects information on race/ethnicity, country of origin, and primary language for all patients we serve.

If you choose to decline submitting this information, please check here: _____
Is the patient of Hispanic, Latino or Spanish origin: Yes No
What is the patient's race/ethnicity (circle one):

American Indian/Alaskan Native	Guamanian/Chamorro	Puerto Rican
Asian Indian	Hmong	Samoan
Black/African-American	Japanese	Somali
Chinese	Korean	Vietnamese
Cuban	Mexican/Mexican-American/Chicano	White/Caucasian
Filipino	Native Hawaiian	

Country of Origin: _____ Primary Language: _____

Patient's Signature: _____ Date: _____

ALLERGIES/REACTIONS (include medications, pollens, foods, latex, venom, or other products)

Medication/Product	Reaction	Medication/Product	Reaction

FAMILY HISTORY

Mother:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Father:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Brother/Sister:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Brother/Sister:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Brother/Sister:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Brother/Sister:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

Brother/Sister:

Living - Yes; Age _____

Living - No; Cause of death _____ Age _____

Lifetime Diseases (if any) _____

PERSONAL/FAMILY HISTORY

Have you or any close members of your family (**not listed above**) including grandparents, aunts, and/or uncles had any of the following medical conditions?

( ) None/Unknown

	Self	Family	Relationship	Age Diagnosed
Allergies/Asthma	( )	( )		
Anxiety/Depression	( )	( )		
Bleeding/Clotting problems	( )	( )		
Bone/Joint disease	( )	( )		
Bowel Disease (e.g. Colitis)	( )	( )		
Eczema/Atopic Dermatitis	( )	( )		
Heart Disease/Heart Attack	( )	( )		
Heartburn/Reflux	( )	( )		
High Blood Pressure	( )	( )		
Immune Deficiencies	( )	( )		
Leukemia/Lymphoma	( )	( )		
Lung Disease (e.g. COPD)	( )	( )		
Lupus	( )	( )		
Osteoporosis	( )	( )		
Other Cancers	( )	( )		
Recurrent Infections	( )	( )		
Skin Disease (e.g. Psoriasis)	( )	( )		
Stroke	( )	( )		
Thyroid Disease	( )	( )		
Tuberculosis	( )	( )		

CURRENT REVIEW OF SYMPTOMS - please circle if you have experienced any of the following:

Cardiac: Chest pain Palpitations Swelling/Edema (location): _____

Endocrinologic: Cold/heat intolerance Excessive thirst Excessive urination Hair growth Hair loss

General: Fatigue Fevers Night sweats Sun sensitivity Unexplained weight loss/gain

GI: Abdominal pain Black stool Blood in stool/on tissue Constipation Diarrhea Nausea

GU: Change in urine color Frequent urination Frequent urine infections Heavy menses Irregular menses Menopausal symptoms (hot flashes/night sweats) Painful urination

HEENT: Bleeding gums Ear pain Eye/ear drainage Eye redness Hearing loss Nasal congestion Nose/mouth ulcers Runny nose Sore throat Thrush Vision change (blurred/double)

Musculoskeletal: Bone pain Joint pain Joint redness Joint swelling Muscle pain Weakness

Neurologic: Headaches Numbness/tingling Seizures Weakness

Psychologic: Anxiety Depression Insomnia Memory loss

Respiratory: Cough Shortness of breath Sputum production Wheezing

Skin: Acne Dry Skin Hives Poor wound healing Rash Swelling Warts

Other: Bruising Dental problems Neck stiffness Nosebleeds Swollen glands/nodes

SOCIAL HISTORY

Marital Status (please circle): Single Married Partnered Separated Divorced Widowed

Do you have children? Yes No
If yes, list their age/name/gender: _____

_____

With whom do you live? _____

Describe where you live (e.g. house, apartment): _____

Do you have any pets? Yes No If yes, list: _____

Do you have problems with?
Pests _____ Rodents _____ Water damage _____

Are you employed? Yes No
If yes, where/title: _____

Do you have smoke exposure? Yes No
If yes, describe: _____

Do you use street drugs? Yes No
If yes, type/quantity/frequency: _____

Do you exercise regularly? Yes No
If yes, type/frequency: _____

Do you follow a special diet? Yes No
If yes, what type: _____

Are you sexually active? Yes No
Number of lifetime sexual partners: _____

Have you ever received a blood transfusion? Yes No
If yes, date/circumstances: _____

Have you travelled internationally? Yes No
If yes, when/where: _____

HEALTH MAINTENANCE

Date of last pap smear: _____ Have you had an abnormal pap? Yes No
If yes, when/what was done? _____

Date of last mammogram: _____ Have you had an abnormal mammogram? Yes No
If yes, when/what was done? _____

Date of last colonoscopy: _____ Have you had an abnormal colonoscopy? Yes No
If yes, when/what was done? _____