Date:_____

Midwest Immunology Clinic, P.A.
Patient Medical History Form

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

Name you prefer to be called:_____

Primary Care MD:_____ **Referring MD**:_____

Main reason for today's visit:_____

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

Current Pharmacy Name/Location:_____

Allergies/Reactions (include medications, pollens, foods, latex, venom, or other products)

Medication/Product	Reaction	Medication/Product	Reaction

Family History

Mother **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
Lifetime Diseases_____ [ ] **None**

Father **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
Lifetime Diseases_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Personal/Family History

[ ] None/unknown

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?

	Self	Family	Relationship	Age Diagnosed
Recurrent infections	[ ]	[ ]		
Immune deficiencies	[ ]	[ ]		
Bleeding/clotting problems	[ ]	[ ]		
Leukemia/lymphoma	[ ]	[ ]		
Other cancers	[ ]	[ ]		
Allergies/asthma	[ ]	[ ]		
Reflux/heartburn	[ ]	[ ]		
Thyroid disease	[ ]	[ ]		
Bone/joint disease (eg, RA)	[ ]	[ ]		
Lupus	[ ]	[ ]		
Eczema/Atopic dermatitis	[ ]	[ ]		
Skin disease (eg, psoriasis)	[ ]	[ ]		
Bowel disease (eg, colitis)	[ ]	[ ]		
Heart disease/heart attack	[ ]	[ ]		
High blood pressure	[ ]	[ ]		
Lung disease (eg, COPD)	[ ]	[ ]		
Anxiety/depresion	[ ]	[ ]		
Stroke	[ ]	[ ]		
Tuberculosis	[ ]	[ ]		
Osteoporosis	[ ]	[ ]		

Current Review of Systems (please check if you are now or recently have experienced any of the following)

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

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

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

Respiratory: Wheezing Cough Shortness of breath Sputum production

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

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

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

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

Neurologic: Headaches Weakness Numbness/tingling Seizures

Psychologic: Anxiety Depression Insomnia Memory loss

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

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

Social History

Marital Status: 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 (eg, 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 traveled 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:_____
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 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.

Is the patient of Hispanic, Latino or Spanish origin: Yes No
What is the patient's race/ethnicity (circle one):

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

Country of origin:_____ Primary Language:_____

Patient's Signature: _____ Date: _____