Form: 2023-01

Tuscarawas County Health Department Medical Clinic

Patient Medical History Form

Date: ______________

Personal Information

Name: ____

Address: ____

Date of Birth: _____________ Age: __________ Email: ____________________________

Gender: ____ Male ____ Female ____ I prefer not to answer

Race: *(select all that apply)*

____ American Indian or Alaskan Native ____ Asian ____ Black or African American

____ Native Hawaiian or Other Pacific Islander _____ White

Are you Hispanic or Latino? YES or NO

Relationship Status: ____Single ____Divorced ____Married ____Widowed ____Separated

Are you currently Employed? YES or NO

If yes, where: ____

Insurance Information

Primary Insurance: ____

Name of Primary Insurance Holder: ________________________DOB:___________

ID#: ____________________________ Group ID#: ____________________

Secondary Insurance: ____

Name of Secondary Insurance Holder: ____________________________________

ID#: ____________________________ Group ID#: ____________________

Medication List

Medication	Dose	Times per Day

Patient Name: ____________________________ Patient Date of Birth: _____________

Allergies

Medication Allergy	Reaction/Side Effect

Past Medical History

Medical Condition	Date of Onset	Treating Doctor	Details
Alcohol/Drug Use			
Anxiety			
Arrythmia			
Arthritis			
Asthma			
Atrial Fibrillation			
Autoimmune Disease			
Bleeding Problems			
Blood Clots			
Cancer			
Circulation Problems			
Congenital Heart Disease			
Coronary Heart Disease			
Depression			
Diabetes			
Digestive Problems			
Hearing Impaired			
Heart Attack			
Heart Failure			
Heart Murmur			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Seizures			
Sleep Disorders			
Stroke			
Thyroid Problems			
Vision Problems			

Other Past Medical History

____

____

____

____

Patient Name: ______________________________ Patient Date of Birth: ____________________

Past Surgical History

Operation	Date	Details

Family History (Mother, Father, Siblings)

Yes or No	Medical History	Family Member Diagnosed
	Alcohol/Drug Use	
	Anxiety	
	Arrythmia	
	Arthritis	
	Asthma	
	Atrial Fibrillation	
	Autoimmune Disease	
	Bleeding Problems	
	Blood Clots	
	Cancer	
	Circulation Problems	
	Congenital Heart Disease	
	Coronary Heart Disease	
	Depression	
	Diabetes	
	Digestive Problems	
	Hearing Impaired	
	Heart Attack	
	Heart Failure	
	Heart Murmur	
	High Blood Pressure	
	High Cholesterol	
	Kidney Disease	
	Liver Disease	
	Seizures	
	Sleep Disorders	
	Stroke	
	Thyroid Problems	
	Vision Problems	
	Other:	
	Other:	

Patient Name: ____ Patient Date of Birth: __________________

Form: 2023-01

Social History

Primary Language: ____ Translator Needed? YES or NO

Do you have any cultural or religious customs we should be aware of? YES or NO

If yes, please explain: ____

Tobacco/Marijuana	Never	Current	Former	Age of Onset	Amount per Day	# of Years	Years Quit
Cigarettes							
Pipe							
Cigar							
Vape							
Marijuana							

Do you drink alcohol? YES or NO ________ # drinks per week

Do you use recreational drugs? YES or NO Type: ____

Review of Current Systems (X) all that Apply

	Activity Change		Apnea		Neck Pain
	Appetite Change		Chest Tightness		Neck Stiffness
	Chills		Choking		Changes in skin color
	Fatigue		Shortness of Breath		Rash
	Fever		Wheezing		New Wounds
	Unexplained Weight Change		Cough		Immunocompromised
	Congestion		Chest Pain		Dizziness
	Dental Problems		Leg Swelling		Headaches
	Ear Discharge		Racing Heart		Light-headedness
	Ear Pain		Stomach Pain		Seizures
	Facial Swelling		Blood in Stool		Numbness
	Hearing Loss		Constipation		Speech Difficulty
	Mouth Sores		Diarrhea		Tremors
	Nose Bleeds		Nausea		Weakness
	Sinus Pressure		Vomiting		Bruises/Bleeding
	Sneezing		Cold Intolerance		Confusion
	Sore Throat		Heat Intolerance		Decreased Concentration
	Ringing in Ears		Difficulty Urinating		Depression
	Trouble Swallowing		Painful Urination		Anxiety
	Voice Change		Genital Sore		Nervousness
	Eye Discharge		Urine Decreased		Self-Injury
	Eye Itching		Frequent Urination		Sleep Disturbances
	Eye Redness		Back Pain		Suicidal Ideas
	Visual Changes		Joint Swelling		Other:

Patient Name: ____ Patient Date of Birth: __________________

Pharmacy Information

Pharmacy Name:____

Address: ____

Phone Number: ____

I give permission for the Tuscarawas County Health Department Medical Clinic to provide medical treatment to me. I understand that I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my clinician.

Patient's Signature: ____________________________________ Date: ______________________

Parent or Guardian Signature (for children under 18): ____

Patient Name: ____ Patient Date of Birth: __________________