Marianjoy Medical Group

Patient Name: _____

Past Medical History

Medical History

Please indicate the conditions you currently have or have had in the past. If No Known Medical History- please indicate here ☐

☐ ADHD	☐ Cerebral Palsy	☐ Hyperlipidemia	☐ Peripheral Artery Disease
☐ Alzheimer's Disease	☐ Chronic Pain	☐ High Blood Pressure	☐ Post-Concussion
☐ Amputation	☐ Congestive Heart Failure	☐ Kidney Disorder	☐ Rheumatoid Arthritis
☐ Aneurysm	☐ COPD	☐ Liver Disease	☐ Seizures/Epilepsy
☐ Atrial Fibrillation	☐ Coronary Artery Disease	☐ Lung Disease	☐ Spinal Cord Injury
☐ Asthma	☐ Depression	☐ Lupus	☐ Spinal Stenosis
☐ Autism	☐ Diabetes Type I	☐ Migraine Headaches	☐ Stroke
☐ Blood/Clotting Disorder	☐ Diabetes Type II	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Brain Tumor	☐ Fibromyalgia	☐ Osteoarthritis	☐ Traumatic Brain Injury
☐ Cancer	☐ Heart Disease	☐ Parkinson's Disease	☐ Other_____

Surgical History

Previous operations:

Type	Year	Type	Year

☐ No Surgeries

Family Medical History:

☐ Check Box if No Known Family Medical Problems **or**:

Please indicate if there is a family member with any of the following conditions and their status using the symbols below:

A=Aunt **B**=Brother **C**=Cousin **D**=Daughter **F**=Father **G**=Grandfather **GM**=Grandmother **M**=Mother **S**=Sister **SN**=Son **U**=Uncle

1=Alive **2**=Deceased **3**=Unknown

☐ ADHD	☐ Cerebral Palsy
☐ Alzheimer's Disease	☐ Chronic Pain
☐ Amputation	☐ Congestive Heart Failure
☐ Aneurysm	☐ COPD
☐ Atrial Fibrillation	☐ Depression
☐ Asthma	☐ Diabetes Type I
☐ Autism	☐ Diabetes Type II
☐ Blood/Clotting Disorder	☐ Fibromyalgia
☐ Cancer	☐ Heart Disease
☐ Hyperlipidemia	☐ Peripheral Artery Disease
☐ High Blood Pressure	☐ Post-Concussion
☐ Kidney Disorder	☐ Rheumatoid Arthritis
☐ Liver Disease	☐ Seizures/Epilepsy
☐ Lung Disease	☐ Spinal Cord Injury
☐ Lupus	☐ Spinal Stenosis
☐ Migraine Headaches	☐ Stroke
☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Osteoarthritis	☐ Other_____
☐ Parkinson's Disease	

Patient Name: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Living Status: ☐ Alone ☐ Spouse ☐ Parents ☐ Adult Children ☐ Significant Other ☐ Caregiver ☐ Children ☐ Other Relative

Living Arrangements: ☐ House ☐ Apartment ☐ Facility

Employment: ☐ Full-time ☐ Homemaker ☐ Long term Disability ☐ Not Working ☐ Part-Time ☐ Retired ☐ Short-term Disability ☐ Student ☐ Unemployed

Occupation: _____

Education: ☐ None ☐ Grade School ☐ High School ☐ High School Equivalent (GED) ☐ Some College/Tech School ☐ College Graduate ☐ Grad School/Advanced Degree

Tobacco Use: ☐ Yes _____Packs/Day ☐ No
☐ Former Smoker-Stop Date/Year_____

Alcohol Use: ☐ Yes _____Drinks/Day/Week ☐ No

Do you use any illegal or recreational drugs?
☐ Yes _____Name of drug
☐ No

Do you have any history or prescription drug abuse?
☐ Yes _____Name of drug
☐ No

Medication Allergies and Type of Reaction/s: _____
_____
_____

☐ No Known Medication Allergies

Medications: Please List Current Prescribed Medications, Supplements, and any Over-the-Counter Medications Below or Attach List-Please Continue on Back of This Page if Needed.

☐ No Current Medications

NAME OF MEDICATION	DOSE	HOW OFTEN IS IT TAKEN/PRESCRIBED
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		