MHC Healthcare
Quality healthcare with a heart!

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Patient Name:_____ DOB:_____ Age:_____ Race:_____

Occupation:_____ Referring Physician:_____

Reason for visit:_____ Date:_____

MEDICATION ALLERGY/SENSITIVITY

List all medication allergies and types of reactions: **None** ☐

_____

_____

CURRENT MEDICATIONS BEING TAKEN & DOSAGES

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY (Check appropriate boxes)

	You	Family
1. High Cholesterol	☐	☐
2. Heart Disease	☐	☐
3. High Blood Pressure	☐	☐
4. Asthma/Lung Disorder	☐	☐
5. Mitral Valve Prolapse	☐	☐
6. Diabetes	☐	☐
7. Thyroid Problems	☐	☐
8. Headaches/Migraines	☐	☐
9. Nervous Disorder or Depression	☐	☐
10. Liver Disease	☐	☐
11. Stomach, Bowel, or Gallbladder Problems	☐	☐
12. Kidney or Bladder Problems	☐	☐
13. AIDS (HIV)	☐	☐
14. Hepatitis (Type:____)	☐	☐
15. Anemia or Blood Disorder	☐	☐
16. Blood Transfusion	☐	☐
17. Breast Problems	☐	☐
18. Cancer	☐	☐
19. Fertility	☐	☐
20. Female or Sexual Problems	☐	☐
21. Chlamydia, Gonorrhea, or Herpes	☐	☐
22. Syphillis	☐	☐
23. Birth Defects or Inherited Diseases	☐	☐
24. Sexual Abuse or Domestic Violence	☐	☐
25. Other Medical Problems	☐	☐
26. No Known Medical Problems	☐	☐
27. Immunizations up-to-date	☐	☐

28. Last Pap Smear_____
29. History of abnormal Pap Smears? ☐ ☐
If yes, when and where treated:
_____

30. Last mammogram? (Date/Place)_____
31. History of abnormal mammogram readings? ☐ ☐

SUBSTANCE USE (Circle only those used)

32. Alcohol: Type:_____ Amt:_____
33. Tobacco: Type:_____ Amt:_____

HOSPITALIZATIONS List operations/serious illnesses that have required hospitalization. If more than four check this box ☐

Month/Year	Illness or Operation	Complications Yes	No
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

MENSTRUAL HISTORY

LMP:___/___/___

Menarche_____

Interval _____

Length of Period_____

Abnormalities:

Excessive Bleeding _____
Discharge _____
Pain _____
None _____

SEXUAL HISTORY

Sexually Active **Y / N**

Age First Intercourse

_____

CONTRACEPTIVE HISTORY

	Current	Past
Oral Contraceptives Type(s):_____		
IUD	◯	◯
Diaphram	◯	◯
Norplant	◯	◯
Sponge	◯	◯
Spermicide	◯	◯
Depo-Provera	◯	◯
Condoms	◯	◯
Sterilization	◯	◯

Other _____

# of Births	DOB MM/YY	Sex	Type of Delivery	Weight At birth	Complications Yes (list)	No
					☐	☐
					☐	☐
					☐	☐
					☐	☐

34. Street Drugs: Type:_____ Amt:_____

Number of Pregnancies: _____
Number of Miscarriages:_____
Number of Abortions:_____