

Compass Health

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MEDICAL HISTORY - FIRST VISIT

Date _____

Legal Name _____ Preferred Name _____ DOB _____

Gender assigned at birth: M / F Gender Identity (if different): _____

MEDICAL HISTORY: *Indicate **past (P)** or **current (C)** next to each applicable condition below or **blank if N/A**

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headache | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ear Problem | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Ulcers / GERD | <input type="checkbox"/> Mouth Problem | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Arthritis ^{OA/RA} |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> TMJ Problem | <input type="checkbox"/> Restless Leg | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Neck Problem | <input type="checkbox"/> Trauma | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Eczema/ Psoriasis |

Urinary Issues: leaking frequency urgency blood can't empty weak stream

Other: _____

Elaborate on above: _____

ALLERGIES: Penicillin Sulfa E-mycin Cephalosporins Morphine Aspirin Codeine NSAIDs

Other meds: _____

Latex Y / N Tape/Adhesive Y / N Iodine Y / N Shellfish Y / N Bees Y / N Nuts Y / N

Environmental _____

Food / Intolerances _____

SCREENING TESTS: (when was the last time you had one done?)

PCP Physical _____ GYN Exam _____ Pap Smear _____ HPV _____

Mammogram _____ Bone Density _____ Routine Blood Work _____

Colonoscopy _____ = wnl / polyps / cancer = Planned next at: 3 yr / 5yr / 10 yr interval

Ultrasound _____ Stress Test _____ EKG _____ Other _____

IMMUNIZATION HISTORY:

Childhood Immunizations Complete? Y / N If No, What is missing: _____

Did you have the Chickenpox Y / N If No, did you receive the Vaccine Y / N Titer? _____

Zostavax Vaccine (Shingles) Y / N Date: _____ Last Flu Shot Date: _____ HPV Y / N Date: _____

Pneumovax Vaccine (pneumonia) Y / N Date: _____ Prevnar 13 Vaccine (pneumonia) Y / N Date: _____

<u>Medications</u>	<u>Dose</u>	<u>Times/Day</u>	<u>Reasons</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Multivitamin _____ Calcium mg/day _____ Vitamin D # IU/day _____ Iron _____ Probiotic _____ Magnesium _____

SEXUAL HEALTH:

Sexual Orientation: _____ Practicing safe sex: Y / N Contraception? _____
Hx Sexually Transmitted Infection: __HPV__ Warts __Herpes__ Chlamydia __Gonorrhea__ Syphilis __HIV__
Sexual Concerns? Y / N __no desire__ __no pleasure__ __orgasm issue__ __impotence__ __dryness__ __pain__

GYNECOLOGY HISTORY: (if applicable)

Total Pregnancies _____ Live Births _____ Miscarriages/Terminations _____ #Living Kids _____
Age Periods Began _____ Age Periods Ended _____ Hyst? Y / N Ablation Y / N
Regular Periods? Y / N Happen how often _____ Last how long _____
Abnormally Heavy _____ Abnormally Painful _____ Bleed Between Periods _____ Bleed After Sex _____
History Abnormal Paps: Y / N When _____ Diagnosis _____ Treatment _____
Vag Symptoms (*itch, pain, burn*) _____ Abn Discharge _____
PMS: Y / N PMDD Y / N Hot Flashes / Night Sweats Y / N

FAMILY HISTORY: *Check applicable boxes

Children: ___living___ deceased

Relative	age of death	Heart Disease	Diabetes	Stroke	Heart Attack	AFib	^ BP	^ Cholesterol	Thyroid	Cancers (type)
Mother										
Father										
Maternal G-Parents										
Paternal G-Parents										
Sisters										
Brothers										
Aunt/Uncle										
Children										

SURGICAL HISTORY:

Surgery _____ Year _____ Where _____
Surgery _____ Year _____ Where _____
Surgery _____ Year _____ Where _____
Surgery _____ Year _____ Where _____

OTHER PROVIDERS:

Ok to share info? **Initial**

PCP (if not here) _____ Location _____ Y / N _____
Psychotherapist _____ Location _____ Y / N _____
Gynecologist _____ Location _____ Y / N _____
Massage Therapist _____ Chiropractor _____ Acupuncturist _____
Other _____ Other _____

LIFE STYLE:

Have a *living will* Y / N Medical *DPA* Y / N -who if yes _____ Ph# _____
Who lives with you _____ Pets _____
Occupation _____ Like Work? _____
Exercise _____ Frequency _____ # meals/day _____ # veggie servings/day _____
Caffeine/day _____ Alcohol/day _____ Street drugs? _____ any ever _____
Tobacco: Y / N type _____ how much / often _____ for how long _____ want to quit _____
Prior Smoker _____ Quit when _____ Sleep Well _____ Need meds to sleep _____
Safe at Home _____ History of Physical, Emotional or Sexual Abuse _____