Midwestern University Multispecialty Clinic
Health History

Today's Date: ___________**Patient Name:** _________________________**DOB:** _________

Gender: _______________ **Date of last physical exam:**_____________

What is the reason for your visit today?

____

____

Symptoms: Check (✓) symptoms you **currently** have

General ☐ Fever/Chills/Night Sweats ☐ Fatigue/weakness ☐ Fainting ☐ Weight loss/gain ☐ Nervousness ☐ Appetite Changes ☐ Other ________________	**Cardiovascular** ☐ Chest pain ☐ Irregular heartbeat ☐ Palpitations ☐ Leg swelling ☐ Leg cramps with exercise ☐ Other ________________	**Dermatologic** ☐ Dry skin ☐ Itchy skin ☐ Rash ☐ Open wound ☐ Moles ☐ Other ________________
Head/Ears ☐ Headache ☐ Hearing Loss ☐ Ear Pain ☐ Other ________________	**Gastrointestinal** ☐ Abdominal pain ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Blood in stool ☐ Other ________________	**Endocrine** ☐ Increased thirst ☐ Increased hunger ☐ Cold or heat intolerance ☐ Hot flashes ☐ Weight gain ☐ Other ________________
Eyes ☐ Blurry Vision ☐ Watery/Itchy Eyes ☐ Glasses/Contacts Last eye exam___________ ☐ Other ________________	**Genitourinary** ☐ Frequent urination ☐ Painful urination ☐ Dark urine ☐ Other ________________	**Psychological** ☐ Mood changes ☐ Thoughts of suicide ☐ Anxiety ☐ Depression ☐ Other ________________
Nose/Throat ☐ Sore Throat ☐ Sinus Problem ☐ Swollen glands ☐ Runny nose ☐ Congestion ☐ Other ________________	**Musculoskeletal** ☐ Pain Site: ____________________ ☐ Joint swelling ☐ Joint stiffness ☐ Muscle weakness ☐ Other ____________________	**Men Only** ☐ Erection problems ☐ Lump in testes/pain ☐ Penile sores/discharge ☐ Prostate Problems ☐ Other ________________
Pulmonary ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Other ________________	**Neurologic** ☐ Dizziness ☐ Loss of sensation ☐ Numbness ☐ Tingling ☐ Burning pain ☐ Other ____________________	**Women Only** ☐ Abnormal periods ☐ Breast lump ☐ Nipple discharge ☐ Vaginal discharge ☐ Painful periods ☐ Other ________________

Preferred Pharmacy: ____

Medications: Please list prescription and over-the-counter medications

Medication	Dose	Times per day

Supplements:

Supplement	Dose	Times per day

Allergies: Please list all allergies, including to medicines, foods, any agents

Allergic To	Reaction or Side Effect

Medical History: Check conditions you currently have or have had in the past

✓ if Yes	Condition	Date	✓ if Yes	Condition	Date
	Allergies			High Cholesterol	
	Alcoholism			Heart Attack	
	Anemia			Hepatitis	
	Arrhythmia			Headaches	
	Arthritis			HIV Infection or AIDS	
	Asthma			High Blood Pressure	
	Autoimmune Condition			Infectious Mono	
	Bleeding Disorder			Kidney Disease	
	Breast Lump			Liver Disease	
	Bronchitis/Pneumonia			Lung Disease	
	Cancer (specify type):			Multiple Sclerosis	
	Congenital Heart Disease (specify type):			Sexually Transmitted Infection	
	Depression/Anxiety			Seizures	
	Diabetes Type I or Type II			Stroke	
	Diverticulosis			Thyroid Problem	
	GERD			Other:	

Surgical History:

Surgical Procedure	Date

Hospitalization and/or Injuries:

Hospitalization/Injury	Date	Outcome

Immunizations: Have you received any of the following and when?

Vaccine	Date(s)
Tetanus	
Prevnar 13 (Pneumonia)	
Pneumovax 23 (Pneumonia)	
Influenza	
Shingrix (Shingles)	
COVID	

Care Team: Please list other members of your healthcare team

Primary Care Physician: ____

Physician	Specialty	City

Last Dental Visit: ____

Last Eye Exam: ____

Women's Health:

1st Day of Last Menstrual Period: __________ Age of Menopause __________

# of Pregnancies __________ # of Deliveries __________ # of Miscarriages_________

When was your last Pap? __________ Normal? □ Yes □ No

When was your last mammogram? __________

Have you ever had a bone density scan (DEXA)? __________ If Yes, when?_________

Family History: Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son
Alcoholism							Glaucoma						
Anemia							Hay Fever						
Asthma							Headaches						
Birth Defects							Hearing Problems						
Bleeding Problem							Heart Disease						
Breast Cancer							High Blood Pressure						
Melanoma							High Cholesterol						
Skin Cancer							Kidney Disease						
Ovarian Cancer							Lupus						
Prostate Cancer							Mitral Valve Prolapse						
Other Cancer							Osteoarthritis						
Type 1 Diabetes							Osteoporosis						
Type 2 Diabetes							Rheumatoid Arthritis						
Eczema							Stroke						
Epilepsy							Thyroid Disorders						
Genetic Diseases							Tuberculosis						
Depression							Mental Illness						
GERD							Other						

Social History:

Alcohol Use: □ Yes □ No # Drinks/Week ____________
Is your alcohol use a concern for you or others? □ Yes □ No

Cigarette Use: □ Never □ Previously Date Quit ______ □ Current: How Long? _______ Amt/Day _______
Are you interested in quitting □ Yes □ No

Other Tobacco Use: □E-Cigarettes/Vape □Cigars □Chewing Tobacco □Pipe

Recreational Drug Use: □ Yes _________________________ □ No

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Occupation: ________________________________

Sleep Patterns: Hours/Night ___________________

Nutrition: Do you follow any specific diet? ___________________________________

Caffeine use: (Coffee, tea, soda) Cups/Day: __________________________________

Physical Activity: □ Yes □ No
Description: ____
Days/Week ______ Minutes/Day ______

Do you feel safe at home? □ Yes □ No

Do you require assistance performing daily tasks? □ Yes □ No
Specify:____

Do you have an Advance Directive (Living Will)? □ Yes □ No

Reviewed By: __________________________________ Date: ___________________

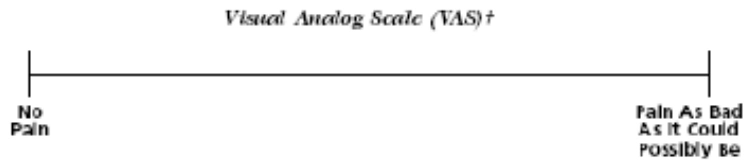
MIDWESTERN UNIVERSITY MULTISPECIALTY CLINIC

Patient Name: ___________________________________ Date: __________________

Patient Date of Birth: ____________________________

Pain Scale

Please identify your level of pain on the scale provided below.



Please describe your pain or condition as it is **today**: (circle)

Aching Burning Squeezing Stabbing Pinching

Throbbing Annoying Pressure Constant

Intermittent Radiates Numbness Tingling Stiffness

Pain Body Map

Please indicate the location of any and all current pain and/or irritation on the body diagrams below