Mercy Clinics, Inc.
A member of Mercy Medical Center–Des Moines

Today's Date _____
Updated Dates _____

PATIENT MEDICAL HISTORY

Name: _____ **Birthdate:**_____
Last First Middle (Month/Day/Year)

PERSONAL HISTORY OF ILLNESS: (Check any illness, past or present)

□ Head Injury	□ADHD/ADD	□Thyroid Disease	□Liver Disease	□ Joint Trouble
□Headache	□Alcohol abuse	□Heart Disease	□Kidney Disease	□High Cholesterol
□Epilepsy (seizure)	□ Eye Disease	□High Blood Pressure	□Anemia	
□Bipolar	□Asthma	□Lung Disease	□Broken Bones	
□Anxiety	□Diabetes	□Pneumonia	□Substance/Prescription drug/Narcotic Abuse	
□Depression	□Cancer	□Stomach Ulcers	□Skin Trouble/Infections	
			□Sexually Transmitted Infections	

□Other_____
_____

SURGERIES AND HOSPITALIZATIONS

Year	Surgery or reason for hospitalization	Year	Surgery or reason for hospitalization
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

ALLERGIES

Are you allergic to any medications? □ Yes □ No If yes, what? _____
Any other allergies (latex, rubber, etc.)?_____

FAMILY HISTORY

Is there any history of the following diseases in your family? If yes, indicate which relative.

DISEASE	WHICH RELATIVE	DISEASE	WHICH RELATIVE
Cancer	_____	Heart Disease	_____
Stroke	_____	High Blood Pressure	_____
Diabetes	_____	Tobacco/Alcohol Abuse	_____
Asthma/Lung Disease	_____	Reaction to Anesthesia	_____
Depression/Mental Illness	_____	Other	_____

SOCIAL HISTORY

□ Married □ Widowed □ Single □Divorced □Partnered Occupation: _____

Are you in a safe environment: □ Yes □ No

Children: □ No □ Yes – How many _____

Caffeine use: □ No □ Yes – How much _____ (coffee, tea, cola)

Exercise: □ No □ Yes – How often _____

Drug Use: □ No □ Yes – How often _____ (Marijuana, LSD, Speed, Heroin, Methamphetamine, Narcotics, etc.)

Alcohol use: □ No □ Yes – How much _____ (including beer and wine)

Tobacco use: □ No If quit, how long did you smoke? _____ □ Yes – How much _____ Year began ____

Do you have a Living Will/Advance Directives/Power of Attorney for Health Care Decisions? □ Yes □ No
Do we have a copy? □ Yes □ No

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PHYSICIAN USE ONLY

Date	Event List

Date	Chronic Problem List