COOK® CLINIC

PATIENT MEDICAL HISTORY FORM

PATIENT MEDICAL HISTORY: The purpose of this form is to give us an overview of your health history. Please fill this out as completely as you can, to the best of your ability. Thank you.

If the patient is not the insured Cook employee, please indicate the insured employee's name:

_____

Relationship to patient: _____ **If married, your spouse's name:** _____

If patient is a child, parent's first and last name: _____

PLEASE PRINT

Insurance ID#: _____

Today's Date: _____ Please give your full name below; what do you like to be called? _____

Patient Name: _____

Street Address: _____ City, State, Zip code: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Marital Status: _____ Date of Birth: _____ Age: _____

_____Male _____ Female

Date of Last Physical Examination: _____ By Whom: _____

Please list below all the medications you are now taking, including nonprescription medications. It is very important that you list the dosage, frequency, and purpose of each one (Example: Dyazide 50 mg twice daily at 9:00 am and 5:00 pm for hypertension):

Prescription:

_____

_____

_____

_____

Non-Prescription:

_____

_____

_____

Please indicate if you or any blood relatives have had, or currently have, any of the following diseases. Be sure to indicate who has the condition.

Cancer (Who and type): _____

High Blood Pressure: _____

Diabetes: _____

Heart Disease: _____

Lung Disease: _____

Kidney Disease or Stones (which?): _____

Mental Illness: _____

Please list any medications that you are allergic to (for example, aspirin, Penicillin):

_____

_____

_____

_____

_____

Please list any other allergies that you have (for example, bee stings, pollen, peanuts):

_____

_____

_____

_____

_____

Do you smoke? _____

If so, how much? _____

If you used to smoke, when did you quit?___

_____

Do you drink alcohol?_____

How often? _____

_____

What medical conditions have you had or do you currently have? Please be specific.

What surgical procedures have you had? Please indicate type of operation and date (or year), include tubal ligation, vasectomy, and tonsillectomy:

Have you ever been hospitalized for an illness other than surgery? If so, please explain the reason for the hospitalization, the date, and where you were hospitalized:

Please list any diagnostic tests you have had in the last two years and indicate where it was done and when. Include x-rays, CT, MRI, and EKG.

Do you have a confirmed pregnancy now? _____

If so, how far along are you? _____

Is there any possibility of an unconfirmed pregnancy? _____

Patient's name: _____ Date of birth: _____