Mercy
MEDICAL CLINIC
A partner with Mercy Health Network–Centerville

PATIENT MEDICAL HISTORY

Patient full name (print) _____ Birthdate_____

Personal History or Illness (check any illness, past or present)

☐Head Injury	☐Asthma	☐Lung Disease	☐Anemia	☐Skin Trouble
☐Migraine Headache	☐Hay Fever	☐Pneumonia	☐Diabetes	☐Gout/Arthritis
☐Epilepsy(seizure)	☐Thyroid Disease	☐Stomach Ulcers	☐Alcohol Abuse	☐High Cholesterol
☐Mental Illness	☐Heart Disease	☐Liver Disease	☐Venereal Disease	☐Rheumatic Fever
☐Eye disease	☐High Blood Pressure	☐Kidney Disease	☐Broken Bones	☐Recurrent Ear Infection
☐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	Relative	Disease	Relative
Cancer	_____	Heart disease	_____
Stroke	_____	High blood pressure	_____
Diabetes	_____	Tobacco/Alcohol	_____
Asthma/Lung disease	_____	Reaction to Anesthesia	_____
Depression	_____	Other	_____

SOCIAL HISTORY

☐ Married ☐Single ☐Divorced ☐Widowed Occupation:_____
Are you in a relationship where you feel unsafe: ☐Yes ☐No
Children: ☐ No ☐ Yes-How many_____ Caffeine use: ☐No ☐Yes-How much_____
Exercise: ☐ No ☐ Yes-How often_____ (coffee, tea, soda)
Drug use: ☐ No ☐ Yes-How often_____ Alcohol use: ☐ No ☐Yes-How much_____
(Marijuana, LSD, Speed, Heroin, Methamphetamine, etc.) (including beer and wine)
Tobacco use: ☐No If quit, how long did you smoke?_____ ☐ Yes-How much_____ Yr. began_____

Do you have a Living Will/Advanced Directives? ☐Yes ☐No Do we have a copy? ☐Yes ☐No