CENTER FOR PREVENTION AND TREATMENT OF INFECTIONS

I.D. MEDICAL HISTORY

Date completed:______________

Name: ____ **DOB:** ____________ ☐ MALE ☐ FEMALE

Referring Physician: ___________________________ **Primary Care Physician:** ___________________________

REASON FOR TODAY'S APPOINTMENT? (Please describe nature and duration of symptoms)

LIST ALL ALLERGIES AND TYPE OF REACTION:

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PAST MEDICAL HISTORY

Please list all past or present medical issues:

☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Frequent urine infections ☐ Tuberculosis ☐ CHF ☐ History of bone infections ☐ History of skin infections ☐ Recent history of tick, mosquito, or other insect bites ☐ MRSA (staph) ☐ HIV / AIDS ☐ Kidney failure ☐ History of pneumonia ☐ Hepatitis

Other:

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Please list all past surgical procedures with approximate dates:

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Please list any recent hospitalizations, ER visits, or Nursing Home stays (date & reason):

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Patient Name: ______________________________________ Patient #: ______________________

Have you ever been immunized for:

Diphtheria	☐No	☐Yes, when?_______	Hepatits A/B	☐No	☐Yes, when?_______
Tetanus	☐No	☐Yes, when?______	Pneumonia	☐No	☐Yes, when?_______
Polio	☐No	☐Yes, when?______	Influenza	☐No	☐Yes, when?_______
German Measles	☐No	☐Yes, when?______	Measles	☐No	☐Yes, when?_______
			Whooping Cough	☐No	☐Yes, when?_______

Have you ever had a skin test for Tuberculosis (TB)? ☐No ☐Yes, when?___________

ROS: Do you now, or have you experienced:

Yes	No		Yes	No		Yes	No	
___	___	headaches	___	___	double or blurred vision	___	___	red, itchy or watery eyes
___	___	ear infection	___	___	fever blisters	___	___	skin problems
___	___	persistent cough	___	___	rapid heart beat	___	___	skipped beats
___	___	swollen feet / ankles	___	___	feel out of breath	___	___	pain in your chest
___	___	faint or pass out	___	___	pain in your abdomen	___	___	heartburn
___	___	trouble swallowing food	___	___	painful bowel movements	___	___	bloody bowel movements
___	___	vomit blood	___	___	feel nervous	___	___	feel depressed
___	___	lose your temper	___	___	worry a lot	___	___	sexual problems
___	___	feel suicidal	___	___	difficulty remembering things	___	___	difficulty concentrating
___	___	severe back pain	___	___	pain or swelling in any joint			

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FAMILY HISTORY

Has any family member had any of the following: Indicate F=father, M=mother, B=brother, S=sister

Cancer	Tuberculosis	Diabetes	Heart Trouble
Stroke	Epilepsy	Mental Illness	Other (specify)
High Blood Pressure	Alcoholism	Thyroid Disease	Other (specify)

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SOCIAL HISTORY

☐ Single ☐ Divorced ☐ Married ☐ Widow(er)   Highest level of education: _________________________

Living Will / Power of Attorney: ☐ Yes ☐ No   Durable Power assigned? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No If yes, type of job _____________________________ ☐ FT ☐ PT

Tobacco use: ☐ Never used ☐ No longer use, year quit: _____ ☐ Still use, ___ packs/day ___years

Alcohol use: ☐ Minimal ☐ Moderate ☐ Heavy ☐ None ☐ Past _________amount

Drug use not by prescription (Substance abuse): Do you use any Opiates, Amphetamines, Cocaine, Marijuana

☐ Yes ☐ No If yes, please list: ____

Do you currently or have you ever used IV Drugs? ☐ Yes ☐ No If yes, explain _________________________

Is it possible you are pregnant? ☐ Yes ☐ No ☐ Not-applicable

Do you have any pets? ☐ Yes ☐ No If yes, list all household animals _________________________________

Are you currently sexually active? ☐ Yes ☐ No

Have you traveled anywhere recently? ☐ Yes ☐ No If yes, please list _________________________________

Patient Name: ____ Patient #: __________________________

MEDICATION LIST

Include prescriptions, over-the-counter medications and any recent antibiotics:

Medication	Dosage	How Many	Route	Frequency	Comments
Example: Tylenol	325 mg.	1	Oral	As needed	Headache, fever

Patient Name: ______________________________ Patient #: ____________________