

Medical History Intake Form

Family Physician or Primary Health Care Provider: _____

Office Phone: _____

Do you have or have you had any of the following (Please check all that apply):

- | | | | |
|---------------------------|--------------------------|----------------------------|--------------------------|
| AIDS/HIV Positive | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> |
| Alzheimer's Disease | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> |
| Anaphylaxis | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | Herpes | <input type="checkbox"/> |
| Arthritis/Gout | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> |
| Artificial Joint | <input type="checkbox"/> | Hives or Rashes | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | Kidney Problem | <input type="checkbox"/> |
| Breathing Problems | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> |
| Chest Pains | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> |
| Cold Sores/Fever Blisters | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |
| Congenital Heart Disorder | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> |
| Convulsions | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> |
| Cortisone Medicine | <input type="checkbox"/> | Radiation Treatments | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Recent weight loss/gain | <input type="checkbox"/> |
| Drug Addiction | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> |
| Easily Winded | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> |
| Epilepsy or Seizures | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | Shingles | <input type="checkbox"/> |
| Excessive Thirst | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Fainting/Dizziness | <input type="checkbox"/> | Sinus Issues | <input type="checkbox"/> |
| Frequent Cough | <input type="checkbox"/> | Spinal Bifida | <input type="checkbox"/> |
| Frequent Diarrhea | <input type="checkbox"/> | Stomach/Intestinal Disease | <input type="checkbox"/> |
| Frequent Headaches | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Genital Herpes | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> |
| Hay Fever | <input type="checkbox"/> | Tonsillitis | <input type="checkbox"/> |
| Heart Attack/Failure | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Heart Pacemaker | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |

If you answered yes to any of the previous conditions, please explain further: _____

SURGERIES: Please list any major surgery and date: _____

HOSPITALIZATIONS: Please list any major hospitalizations, date and reason for stay: _____

MEDICATIONS: List any prescription medications and supplements you are currently taking: _____

ALLERGIES: List any drug or medical materials (latex) allergies and reaction: _____

FAMILY MEDICAL HISTORY: Please list any major medical issues that have occurred in your family: _____

SOCIAL HISTORY:

Do you use tobacco? yes no If yes, how many packs or cigarettes per day _____

Do you drink alcohol yes no If yes, how many drinks per week _____

To the best of my knowledge, the questions above on the form have been accurately answered. I understand that providing incorrect information can be dangerous to the treating staff, other patients and my health. It is my responsibility to update NeuroHope of Indiana of any changes in medical status.

Subject Name (Printed)

Date

Subject Signature

Date

Caregiver/Power of Attorney(Printed)

Date

Caregiver/Power of Attorney Signature

Date