

office use only - place label or print here

Patient name: _____
MRN: _____
DOB: _____
Date: _____

Dear Patient:

The following questions will help us complete a comprehensive assessment of your health as part of your visit today. If you object to answering any of these questions or if you find any of them unclear or too personal, just leave them blank. We can discuss any concerns during your visit. This form will be filed in your confidential medical record along with the notes of your visit today.

Reason for Visit / What do you want to talk about _____

1. PATIENT HISTORY

Have you ever, or do you now have any of the following?

<input type="checkbox"/> anemia	<input type="checkbox"/> eating problems	<input type="checkbox"/> melanoma
<input type="checkbox"/> anorexia	<input type="checkbox"/> depression	<input type="checkbox"/> menstrual problems
<input type="checkbox"/> arthritis	<input type="checkbox"/> diabetes	<input type="checkbox"/> migraines
<input type="checkbox"/> asthma	<input type="checkbox"/> epilepsy or seizures	<input type="checkbox"/> sexually transmitted disease
<input type="checkbox"/> cancer	<input type="checkbox"/> heart disease	<input type="checkbox"/> thyroid problems
<input type="checkbox"/> chicken pox	<input type="checkbox"/> high/low blood pressure	<input type="checkbox"/> other, please list _____

Have you had any recent weight gain/loss? yes no

Have you recently experienced sadness, stress, or anxiety that interfered with your daily activities? yes no

Do you currently have pain? yes no

If yes, please rate your pain on a scale from 0 - 10? (0 = no pain, 10 = worst pain) _____

If yes, location of pain? _____

Please list all hospitalizations you have had (surgical, medical, psychiatric) and the year _____

2. FAMILY HISTORY

	Diabetes	Hypertension/ High Blood Pressure	High Cholesterol	Heart Attack	Cancer (type)	Genetic Disease	Other (type)
Father							
Mother							
Sibling							
Other blood relative							

3. HEALTH RISK ASSESSMENT

Do you drink alcohol? yes no If yes, # of drinks per week _____

Do you smoke? yes no If yes, # of cigarettes per day _____

Have you ever used recreational/ street drugs? yes no

Have you ever misused prescribed drugs? yes no

Do you exercise regularly? yes no

Are you satisfied with your eating habits? yes no

Are there any significant issues affecting family/ significant others? yes no

If yes, please explain _____

Are there any religious/ cultural consideration regarding your care? yes no

If yes, please explain _____

Do you have any questions about sexually transmitted diseases? yes no

Would you like to be tested for STDs? yes no

4. MEDICATIONS, ALLERGIES, and IMMUNIZATIONS

Please complete section 4 A - C, **unless** you have a POL* account and you have reviewed and verified the accuracy of the information in your account.

* For more information on Patient Online (POL), please visit: <http://pol.mit.edu>

A. Medications

List any prescription and non-prescription medication you take regularly (include OTC, herbals, vitamins, etc) _____

B. Allergies

Do you have any allergies to medications? yes no

If yes, please list medication(s) and reaction: _____

Do you have any of the following allergies?

food latex medications environmental other _____

C. Immunizations

Tetanus/ diphtheria (recommended every 10 years) _____

Date _____

Annual flu vaccines? _____

yes no

Hepatitis B (check one) _____

had illness vaccinated not vaccinated don't know

Chicken pox (check one) _____

had illness vaccinated not vaccinated don't know

Pneumococcal _____

Date _____

Other vaccines, please list with name and date: _____

5. FUNCTIONAL ASSESSMENT

Does your health limit you in any activities?

working yes no

daily chores yes no

moderate exercise yes no

vigorous exercise yes no

If yes, please explain _____

6. LEARNING NEEDS ASSESSMENT

Do you have any of the following?

learning disabilities yes no

visual limitations yes no

hearing limitations yes no

If yes, please explain _____

The health and wellness of everyone in the MIT community is important to us at MIT Medical. We recommend the following:

- Condom use during sexual activity to reduce the risk of STDs and unintended pregnancy.
- Use of automobile safety belts to reduce the risk of injury or death, which is the law in Massachusetts.
- Use of helmets while bicycling, roller blading, skate boarding, etc to reduce the risk of injury.
- Home smoke detectors to reduce the risk of injury or damage from a fire.
- Use of sunscreen SPF 15 or higher for you and your children when in the outdoor sun.

SIGNATURE

Patient signature _____

Date _____

Provider signature _____

Date _____