Midwest Immunology Clinic
Patient Medical History Form (ADULT)

Appointment Dates:____________________

Patient Name:____________________**DOB:**__________**Age:**______

E-mail address: ____________________ **(for automated appt reminders)**

REFERRING MD: ____________________

Location/Phone: ____________________

PRIMARY CARE MD: ____________________

Location/Phone: ____________________

Main reason for today's visit:____________________

Current Pharmacy Name/Location: ____________________

MEDICAL HISTORY

Diagnosis	Date Diagnosed	Care Provider	**Medications/Therapies For This Diagnosis** (name/dosing/prescriber)

SURGICAL HISTORY

Date	Surgery	Provider/Hospital

HOSPITALIZATIONS (not including surgeries listed above)

Date	Reason	Provider/Hospital

OTHER MEDICATIONS (please include vitamins, herbal supplements, and over-the-counter medications)

Medication	Dosage	Prescribing MD/NP	Medication	Dosage	Prescribing MD/NP

ALLERGIES/REACTIONS (include medications, pollens, foods, latex, venom, or other products)

Medication/Product	Reaction	Medication/Product	Reaction

FAMILY HISTORY

Mother: Living - Age ______
Deceased - Age _____ Cause of death ______
Lifetime diseases (if any): ______

Father: Living - Age ______
Deceased - Age _____ Cause of death ______
Lifetime diseases (if any) ______

Siblings: Number living & Ages ______
Number deceased & Cause of death ______
Lifetime diseases (if any) ______

Maternal Grandmother:
Living - Age ______
Deceased - Age _____ Cause of death ______
Lifetime diseases (if any) ______

Maternal Grandfather:
Living – Age ______
Deceased - Age _____ Cause of death ______
Lifetime diseases (if any) ______

Paternal Grandmother:
Living – Age ______
Deceased – Age _____ Cause of death ______
Lifetime diseases (if any) ______

Paternal Grandfather:
Living – Age: ______
Deceased – Age _____ Cause of death ______
Lifetime diseases (if any): ______

Children:
Number living & Ages ______
Number deceased & Cause of death ______
Lifetime diseases (if any) ______

CURRENT REVIEW OF SYMPTOMS - circle if you are currently experiencing any of the following:

General:	Fatigue Fevers Night sweats Weight loss Weight gain
Skin:	Bruising Dry skin Hives Rash Swelling Warts
HEENT:	Dry eyes Eye redness Vision change Ear pain Ear drainage Hearing loss
	Nasal congestion Mouth ulcers Runny nose Sore throat Thrush
Neck:	Swollen glands Neck stiffness/pain
Respiratory:	Cough Shortness of breath Sputum production Wheezing
Cardiovascular:	Chest pain Fainting Vomiting Heartburn Reflux Palpitations
	Swelling/Edema (location): ______________________
GI:	Abdominal pain Blood in stool/on tissue Constipation Diarrhea Nausea
GU:	Change in urine color Frequent urination Frequent urine infections Heavy menses
	Irregular menses Menopausal symptoms (hot flashes/night sweats) Painful urination
Musculoskeletal:	Joint pain Joint redness Joint swelling Muscle pain Weakness
Neurologic:	Headaches Numbness/tingling Seizures Weakness Developmental delay
Psychiatric:	Anxiety Depression Insomnia Memory loss
Endocrinologic:	Cold intolerance Heat intolerance Excessive thirst Excessive urination
	Hair growth Hair loss
Hematologic:	Abnormal bleeding Anemia Enlarged lymph nodes Petechiae

SOCIAL HISTORY

Marital Status (please circle): Single Married Partnered Separated Divorced Widowed

Do you have children? Yes No If yes, list their age/name/gender: ______________________________

____

With whom do you live? ____

Describe where you live (e.g. house, apartment): ____________________________________

Do you have any pets? Yes No If yes, list: ____

Do you have problems with: Pests ____________ Rodents ____________ Water damage __________

Are you employed? Yes No If yes, where/title: ____

Do you have smoke exposure? Yes No If yes, describe: ___________________________________

Do you use street drugs? Yes No If yes, type/quantity/frequency: ___________________________

Do you exercise regularly? Inactive Light Moderate Heavy Vigorous
If yes, type/frequency: ____

Do you follow a special diet? Yes No If yes, what type: ___________________________________

Are you sexually active? Yes No

Have you ever received a blood transfusion? Yes No
If yes, date/circumstances: ______________________________

Have you travelled internationally? Yes No
If yes, when/where: ______________________________

HEALTH MAINTENANCE

Date of last pap smear: ____________ Have you had an abnormal pap? Yes No
If yes, when/what was done? ______________________________

Date of last mammogram: ____________ Have you had an abnormal mammogram? Yes No
If yes, when/what was done? ______________________________

Date of last colonoscopy: ____________ Have you had an abnormal colonoscopy? Yes No
If yes, when/what was done? ______________________________

Date of last bone density (DEXA) scan: ________ Have you had an abnormal DEXA scan? Yes No
If yes, when/what was done? ______________________________

Date of last pulmonary function test (PFTs): ______ Have you had an abnormal PFTs? Yes No
If yes, when/what was done? ______________________________

Have you ever had a TB skin test (PPD/Mantoux)? Yes No If yes, date: ________ Result: __________

FEDERAL RACE/ETHNICITY INFORMATION

In compliance with Federal regulations, Midwest Immunology Clinic collects information on race/ethnicity, country of origin, and primary language for all patients we serve.

If you choose to decline submitting this information, please check here: ________
Is the patient of Hispanic, Latino or Spanish origin: Yes No

What is the patient's race/ethnicity (circle one):

American Indian/Alaskan Native	Guamanian/Chamorro	Puerto Rican
Asian Indian	Hmong	Samoan
Black/African-American	Japanese	Somalian
Chinese	Korean	Vietnamese
Cuban	Mexican/Mexican-American/Chicano	White/Caucasian
Filipino	Native Hawaiian	

Country of Origin: ______________ Primary Language: ______________

PATIENT'S SIGNATURE: ______________________ **DATE:** __________

Midwest Immunology Clinic
Patient Medical History Form (PEDIATRIC)

Appointment Dates: ______________________________

Patient Name: ______________________________ **DOB:** ____________ **Age:** _____

Mother's Name: ____________________ **Father's Name:** ____________________

E-mail address: ______________________________ **(for automated appt reminders)**

REFERRING MD: ______________________________

Location/Phone: ______________________________

PRIMARY CARE MD: ______________________________

Location/Phone: ______________________________

Main reason for today's visit: ______________________________

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MEDICAL HISTORY

Diagnosis	Date diagnosed	Care Provider	**Medications/Therapies for this diagnosis** (name/dosing/prescriber)

SURGICAL HISTORY

Date	Surgery	Provider/Hospital

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OTHER MEDICATIONS (please include vitamins, herbal supplements, and over-the-counter medications)

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Deceased – Age _____ Cause of death ____________________
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Neurologic: Headaches Numbness/tingling Seizures Weakness Developmental delay

Psychiatric: Anxiety Depression Insomnia Memory loss

Endocrinologic: Cold intolerance Heat intolerance Excessive thirst Excessive urination
Hair growth Hair loss

Hematologic: Abnormal bleeding Anemia Enlarged lymph nodes Petechiae

SOCIAL HISTORY

With whom does your child primarily live ______________________________

Does your child live in multiple households Yes No

Describe the household(s) where your child lives (e.g. house, apartment) ______________________

____

Do you have any pets? No If yes, list: ______________________________

Do you have problems with: Pests ____________ Rodents ____________ Water damage ____________

Does your child attend daycare/school? No If yes, where/what grade: ______________________

____

Are you (or your child's parents/guardians) employed? No If yes, where/title: ______________________

____

Does your child have smoke exposure? No If yes, describe: ______________________

Does your child follow a special diet? No If yes, what type: ______________________

Has your child received a blood transfusion? No If yes, date/circumstances: ______________________

Has your child travelled internationally? No If yes, when/where: ______________________

____

HEALTH MAINTENANCE

Date of last vision screening:______________________ History of abnormal vision screen: Yes No
If yes, when/what was done:____

Date of last pulmonary function test (PFTs):___________ History of abnormal PFTs: Yes No
If yes, when/what was done:____

Date of last bone density (DEXA) scan:_______________ History of abnormal DEXA scan: Yes No
If yes, when/what was done:____

Has your child received a tuberculin (TB) skin test (eg, PPD/Mantoux): Yes No
If yes, date:_________ Result_________________________

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Asian Indian
Black/African-American
Chinese
Cuban
Filipino
Guamanian/Chamorro
Hmong
Japanese
Korean
Mexican/Mexican-American/Chicano
Native Hawaiian
Puerto Rican
Samoan
Somalian
Vietnamese
White/Caucasian

Country of Origin: ____________________ Primary Language: ____________________

Parent/Guardian Name: ______________________________ **Date:** _________________

Parent/Guardian Signature: ________________________________