Group Health Cooperative of South Central Wisconsin

General Medical History Form: ADULT

Name:	**Date:**	**GHC-SCW#:**	
Address:	**City:**	**State:**	**Zip Code:**
Home Phone: ( )	**Work Phone: ( )**	**email:**	
DOB:	**Marital Status:** ☐Divorced ☐Separated ☐Married ☐Sig Other ☐Single ☐Widowed ☐Other		
Maiden/Other Names: (1)	(2)	(3)	
Emergency Contact 1:	Relation:	Hm:( )	Wk:( )
Emergency Contact 2:	Relation:	Hm:( )	Wk:( )
Occupation:	Employer:		

Ethnic Group: ☐African American ☐American Indian/Eskimo ☐Asian/Pacific Islander ☐Caucasian ☐Hispanic/Latino ☐Multi-Racial

Language Preference: **Cultural Needs and Preferences:**

Allergies (include date noted if known):

Medications (include dose if known):

Health concerns to be addressed at appointment:

Females: Last menstrual period: _____ Frequency of menstruation: every _____ days # of days you flow _____
Last Pap: _____ ☐ Normal ☐Abnormal PMS: ☐No ☐Yes Cramping: ☐None ☐Mild ☐Moderate ☐Severe

Tobacco Use Status: ☐Current ☐Former ☐Never
Does anyone in the household use tobacco? ☐Yes ☐No Comments: _____
☐Cigarette packs/day:_____ #Years:_____ Quit Date:_____ Other types: ☐Pipe ☐Snuff ☐Cigar ☐Chew

Alcohol: ☐No ☐Yes oz/week:_____ Comment:

Drug Use: ☐No ☐Yes times per week:_____ ☐IV use Comment:

Sexual Health: Partners: ☐Male ☐Female
Sexually Active: ☐Not Currently ☐Yes ☐No
Contraception Method: ☐Condom ☐Injection ☐Sponge ☐Pill ☐Insert ☐Abstinence ☐Diaphragm ☐Surgical ☐Spermicide ☐Implant ☐Rhythm ☐IUD ☐Other:

Date and Diagnosis of any sexually transmitted disease:
_____
_____
Symptoms of discharge, itching or lesions: _____
_____

Activities of Daily Living / Misc: ☐Check here if there has been no change in this area since you last completed this form

Military Service:	☐No	☐Yes	Sleep Concern:	☐No	☐Yes	Exercise regularly:	☐No	☐Yes
Blood Transfusion:	☐No	☐Yes	Stress Concern:	☐No	☐Yes	Wear Bike Helmet:	☐No	☐Yes
Caffeine Concern:	☐No	☐Yes	Weight Concern:	☐No	☐Yes	Wear Seat Belt:	☐No	☐Yes
Occupational Exposure:	☐No	☐Yes	Follow Special Diet:… ...	☐No	☐Yes	Perform Self Exams:	☐No	☐Yes
Hobby Hazards:	☐No	☐Yes	Practices Back Care:	☐No	☐Yes	Other: _____		

Immunization Dates: ☐Check here if there has been no change in this area since you last completed this form

Tetanus Booster: _____ Hepatitis B: _____
Chicken Pox (or date of illness) _____ Hepatitis A: _____
Influenza: _____ MMR: _____
Pneumovax:_____ Rubella: titer date: _____ disease date: _____
Other: _____ Other: _____

Entered into Epic by PCS Staff: _____ Date: _____

over please

Group Health Cooperative of South Central Wisconsin

GENERAL MEDICAL HISTORY FORM, ADULTS (Continued)

☐Check here if there has been no change on this page since you last completed this form

Long-Term Illness/Chronic Medical Concerns

Illness	Date of Diagnosis

Surgery History

Surgical Procedure	Date
Date of last mammogram	
Date of last flex sigmoidoscopy	
Date of last lipid test	

Above section entered into Epic by Provider: _____

Are you adopted? ☐yes ☐no

Check family members who have the following conditions	No History	Mother	Father	Sister	Brother	Maternal Grandmo	Maternal Grandfath	Paternal Grandmo	Paternal Grandfath	Daughter	Son	Other
Coronary Heart Disease												
Congenital Heart Disease												
Hyperlipidemia (high cholesterol)												
Diabetes Mellitus												
Depression												
Mental Health Problems												
High Blood Pressure												
Stroke												
Cancer – Breast												
Cancer – Colon												
Cancer – Prostate												
Other Cancers: Type												
Alcoholism/Drug Abuse												
Asthma/Allergies												
Migraines												
Obesity												
Anesthesia Problems												
Arthritis												
Blood Disease/Anemia												
Cystic Fibrosis												
Genetic Disorders												
Stomach/Intestinal Problems												
Genital/Urinary problems												
Kidney Disease												
Lung Problems												
Multiple Sclerosis												
Osteoporosis												
Thyroid Disorders												
Tuberculosis												
HIV/AIDS												
Seizure Disorder												
Other:												

Provider OK to enter into Epic: _____

Entered into Epic by PCS Staff:_____

Family History

	Alive	If Deceased: Age at Death	If Deceased: Cause of Death
Mother			
Father			
Circle One			
Sibling M F			
Sibling M F			
Sibling M F			
Sibling M F			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Circle One			
Child M F			
Child M F			
Child M F			
Spouse/Other M F			

OB/GYN History

please indicate date of delivery and check outcome for each

		Normal Vaginal Delivery	Cesarean Section	Forceps-Vaginal Delivery	Vacuum Vaginal Delivery	Ectopic Pregnancy	Miscarriage	TAB
Pregnancy 1	date							
Pregnancy 2	date							
Pregnancy 3	date							
Pregnancy 4	date							
Pregnancy 5	date							

Family Hx and OB/Gyn Hx Entered into Epic by PCS Staff:_____