Group Health Cooperative of South Central Wisconsin

GENERAL MEDICAL HISTORY FORM - ADULT

Name:	**Date:**	**Member#:**
Home Phone: ( )	**Work Phone: ( )**	**e-mail:**
DOB:	**Marital Status:** ☐Divorced ☐Separated ☐Married ☐Sig Other ☐Single ☐Widowed ☐Other	
Maiden/Other Names: (1)	(2)	(3)
Occupation:	**Employer:**	
Ethnic Group: ☐African American ☐American Indian/Eskimo ☐Asian/Pacific Islander ☐Caucasian ☐Hispanic/Latino ☐Multi-Racial		
Language Preference:	**Cultural Needs & Preferences:**	
Emergency Contact 1:	Relation:	Hm: ( ) Wk: ( )
Emergency Contact 2:	Relation:	Hm: ( ) Wk: ( )

Allergies (Attach list if more space is needed):

Medications (Attach list if more space is needed):

Today's Health Concern:

Females: Last Pap: _____ ☐ Normal ☐Abnormal ☐ Menopause/Hysterectomy _____
Last Menstrual Period: _____ Menstruation Frequency: Every____days Number of Days You Flow:_____ PMS: ☐No ☐Yes Cramping: ☐None ☐Mild ☐Moderate ☐Severe

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

Drug Use: ☐No ☐Yes Times per week: _____ ☐IV use Comments:

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

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

Alcohol Use: ☐No ☐Yes [Beer ___ Drinks/Week] [Wine ___ Drinks/Week] [Hard Alcohol ___Drinks/Week]
How often did you have a drink containing alcohol in the past year? ☐ Never ☐ Monthly or less ☐ 2-4x/mo ☐ 2-3x/wk ☐ 4 or more/wk
How many drinks did you have on a typical day within the past year? ☐ 0 to 2 ☐3 to 4 ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more
How often did you have six or more drinks on one occasion in the past year? ☐Never ☐ Less than Monthly ☐ Monthly ☐Weekly ☐Daily or almost daily

Domestic Violence: Violence can be a problem in many people's lives, and so now we ask every patient we see about trauma or abuse they may have experienced in a relationship. Do you feel safe in your relationship? ☐Yes ☐No

Exercise: ☐No ☐Yes: (If "yes," type of exercise:_____) How many days/wk? _____ How many minutes/wk? _____

Activities of Daily Living/Misc: ☐Check here if there has been no change in this area since you last completed this form
Military Service ☐Yes ☐No Sleep Concern ☐Yes ☐No Wears Bicycle Helmet ☐Yes ☐No Weight Concern ☐Yes ☐No
Wears Seat Belt ☐Yes ☐No Performs Self-Exams ☐Yes ☐No Occupational Exposure ☐Yes ☐No Special Diet ☐Yes ☐No
Gun(s) in Home ☐Yes ☐No Other:

Continued on reverse

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

Long-Term Illness/Chronic Medical Concerns	
Illness	**Diagnosis Date**

Surgery History	
Surgical Procedure	**Date**

Are you adopted? ☐ Yes ☐ No **Family history unknown** ☐ Yes

Relationship	Coronary heart disease	Premature coronary heart disease	Congenital heart disease	Hyperlipidemia	Diabetes	Depression	Mental health problem	Hypertension	Stroke	Breast cancer	Colon cancer	Prostate cancer	Cancer	Alcoholism	Asthma	Allergies	Migraine	Obesity	Anesthesia	Genetic	Multiple sclerosis	Osteoporosis	Thyroid	Tuberculosis	HIV/AIDS	Epilepsy	Other
Mother																											
Father																											
Sister																											
Brother																											
Daughter																											
Son																											
MAunt																											
MUncle																											
PAunt																											
PUncle																											
MGMo																											
MGFa																											
PGMo																											
PGFa																											
Other																											

If Other, specify _____

Family Member	**FAMILY HISTORY**			
	Alive	**Name**	**Age at Death** (if deceased)	**Cause of Death** (if deceased)
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 Indicate date of delivery and check outcome for each **Date:**		Normal vaginal delivery	Cesarean Section	Forceps – vaginal delivery	Vacuum – vaginal delivery	Ectopic pregnancy	Miscarriage	Abortion
Pregnancy 1								
Pregnancy 2								
Pregnancy 3								
Pregnancy 4								
Pregnancy 5								