Patient name:_____

MRN:_____

DOB:_____ Date:_____

Patient Health History

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

_____

_____

Patient history

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

- ☐ anemia
- ☐ anorexia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ chicken pox
- ☐ eating problems
- ☐ depression
- ☐ diabetes
- ☐ epilepsy or seizures
- ☐ heart disease
- ☐ high/low blood pressure
- ☐ melanoma
- ☐ menstrual problems
- ☐ migraines
- ☐ sexually transmitted disease
- ☐ thyroid problems
- ☐ other, please list: _____

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

_____

_____

Family history

If yes, check all that apply:

Breast Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Colon Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Diabetes	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Genetic Disorder	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Heart Disease	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
High Blood Pressure	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
High Cholesterol	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative
Other Cancer	☐ no	☐ yes	☐ father	☐ mother	☐ sibling	☐ other blood relative

Health risk assessment

Do you drink alcohol? ☐ no ☐ yes

If yes, # of drinks per week:_____

Do you smoke or use other forms of tobacco? ☐ no ☐ yes ☐ former

If former, quit date:_____

Have you ever used recreational/street drugs? ☐ no ☐ yes

Have you ever misused prescribed drugs? ☐ no ☐ yes

Do you exercise regularly? ☐ no ☐ yes

Are you satisfied with your eating habits? ☐ no ☐ yes

Over the past two weeks, how often have you had little interest or pleasure in doing things? Select one response.

☐ not at all ☐ several days ☐ more than half of the days ☐ nearly every day

Patient name:_____

MRN:_____

DOB:_____ Date:_____

Over the past two weeks, how often have you been down, depressed, or hopeless? Select one response.

☐ not at all ☐ several days ☐ more than half of the days ☐ nearly every day

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

If yes, please explain:_____

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

If yes, please explain:_____

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

Would you like to be tested for sexually transmitted diseases? ☐ no ☐ yes

Are you having any experiences on campus and/or at home that make you feel unsafe? ☐ no ☐ yes

Allergies and immunizations

Please complete section 4 A-B unless you have a HealthELife account and you have reviewed and verified the accuracy of the information in your account.

For more information on HealthELife, please visit medical.mit.edu/healthelifeinfo

A. Allergies

Do you have any allergies to medications? ☐ no ☐ yes

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

_____

_____

B. Immunizations

Please bring any immunization information with you to your appointment.

C. Medications

Please bring any medication information with you to your appointment.

Learning needs assessment

Do you have any of the following:

Learning disabilities? ☐ no ☐ yes

Visual limitations? ☐ no ☐ yes

Hearing limitations? ☐ no ☐ yes

If yes, please explain:_____

_____

_____

Review of systems

Are you currently experiencing any of the following…?

a. **General**

☐ fatigue ☐ trouble sleeping ☐ weight changes ☐ weakness ☐ fever

☐ Pain, rated on a scale from 0–10 (0 = no pain, 10 = worst pain):_____

Patient name:_____

MRN:_____

DOB:_____ Date:_____

b. **Functional assessment**

Is your health limited in any of the following activities:

Work? ☐ no ☐ yes **Moderate exercise?** ☐ no ☐ yes

Daily chores? ☐ no ☐ yes **Vigorous exercise?** ☐ no ☐ yes

If yes, please explain:_____

c. **Skin**

☐ rashes ☐ itching ☐ color changes ☐ lumps ☐ dryness ☐ hair and nail changes

d. **Head**

☐ headache ☐ head injury

e. **Ears**

☐ earache ☐ tinnitus ☐ drainage ☐ decreased hearing

f. **Eyes**

☐ vision ☐ flashing lights ☐ cataracts ☐ glasses/contacts ☐ blurry or double vision

☐ pain ☐ specks ☐ redness ☐ glaucoma ☐ last eye exam:_____

g. **Nose**

☐ itching ☐ nosebleeds ☐ stuffiness ☐ discharge ☐ hay fever ☐ sinus pain

h. **Throat/Mouth**

☐ teeth ☐ sore tongue ☐ thrush ☐ gums ☐ dry mouth ☐ non-healing sores

☐ bleeding ☐ sore throat ☐ dentures ☐ hoarseness ☐ last dental exam:_____

i. **Neck**

☐ lumps ☐ pain ☐ swollen glands ☐ stiffness

j. **Breasts**

☐ lumps ☐ discharge ☐ breastfeeding ☐ pain

k. **Respiratory**

☐ cough ☐ mucus ☐ coughing up blood ☐ shortness of breath ☐ wheezing ☐ painful breathing

l. **Cardiovascular**

☐ chest pain or discomfort ☐ difficulty breathing lying down ☐ tightness ☐ palpitations

☐ sudden awakening from sleep with shortness of breath ☐ shortness of breath with activity ☐ swelling

m. **Gastrointestinal**

☐ diarrhea ☐ constipation ☐ change in appetite ☐ nausea ☐ change in bowel habits

☐ heartburn ☐ rectal bleeding ☐ swallowing difficulties ☐ yellow eyes or skin (jaundice)

n. **Urinary**

☐ increased frequency ☐ loss of control of urine ☐ change in urinary strength

☐ urgency ☐ burning or pain ☐ blood in urine (hematuria)

o. **Genital**

Patient name:_____

MRN:_____

DOB:_____ Date:_____

Male

☐ hernia ☐ pain with sex ☐ genital sores ☐ penile discharge ☐ erectile dysfunction

☐ STD's:_____ ☐ scrotal masses or pain

Female

☐ pain with sex ☐ hot flashes ☐ vaginal itching or rash ☐ vaginal dryness ☐ vaginal discharge

☐ STD's:_____ ☐ last menstrual period:_____ ☐ genital sores

p. **Vascular**

☐ calf pain with walking ☐ cramping

q. **Musculoskeletal**

☐ back pain ☐ stiffness ☐ swelling of joints ☐ trauma ☐ redness of joints ☐ muscle or joint pain

r. **Neurologic**

☐ dizziness ☐ weakness ☐ numbness ☐ tremor ☐ seizures ☐ tingling ☐ fainting

s. **Hematologic**

☐ ease of bruising ☐ ease of bleeding

t. **Endocrine**

☐ heat or cold intolerance ☐ frequent urination ☐ sweating ☐ thirst ☐ change in appetite

u. **Psychiatric**

☐ stress ☐ memory loss ☐ nervousness ☐ depression

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, rollerblading, 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

Patient name (PRINT):_____ DOB:_____

Patient signature:_____ Date:_____

Provider signature:_____ Date:_____