MITMedical
http://web.mit.edu/medical

Patient Health History

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?

☐ anemia	☐ eating problems	☐ melanoma
☐ anorexia	☐ depression	☐ menstrual problems
☐ arthritis	☐ diabetes	☐ migraines
☐ asthma	☐ epilepsy or seizures	☐ sexually transmitted disease
☐ cancer	☐ heart disease	☐ thyroid problems
☐ chicken pox	☐ high/low blood pressure	☐ 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://web.mit.edu/medical/login.html**

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 _____