Cochran Memorial Hospital
Morton Rural Health Clinic

Patient Past Medical History Questionnaire

Cochran Memorial Hospital and Clinic

Today's Date:	Gender: ☐ M ☐ F ☐ N ☐ T
Name:	Date of Birth:
Primary Language	Occupation
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Highest Education Level
Emergency Contact/ Relationship	
Emergency Contact Phone Number	Preferred Pharmacy
Primary Care Provider	
Specialists Previously Seen	

SURGICAL HISTORY

☐ Appendix ☐ Tonsils ☐ Gallbladder ☐ Colonoscopy ☐ Upper GI Scope ☐ Hernia Repair
☐ Hysterectomy +/- ovaries ☐ Knee Replacement ☐ Hip Replacement ☐ Ankle Replacement
☐ Shoulder Replacement ☐ Heart Surgery – Bypass ☐ Hear Surgery – Valve Replacement
☐ Angiogram ☐ Stents ☐ Pacemaker ☐ Other_____

PREVENTATIVE TESTS & DATE

☐ Physical Exam _____ ☐ Bone Density_____ ☐ Mammogram_____
☐ Colonoscopy_____ ☐ Upper GI Scope_____ ☐ Stress Test _____
☐ EKG_____ ☐ Chest CT Scan_____ ☐ Echocardiogram_____

INJURIES

☐ Back ☐ Neck ☐ Head ☐ Broken Bones ☐ Other_____

BIRTH HISTORY

Were you born prematurely? ☐ Yes ☐ No
Were there any complications during your birth? ☐ Yes ☐ No

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HOSPITALIZATIONS & DATES

_____

_____

WOMEN'S HEALTH HISTORY

Last Mammogram	Last PAP Smear	Bone Density Scan
Breast Biopsy	Cervical Biopsy	

Pregnancies/Children

Number of Pregnancies	C-Sections	Vaginal Births
Miscarriages	Abortions	Live Births

☐ Post Partum Depression ☐ Gestational Diabetes ☐ Baby over 8 pounds ☐ Breast feeding

Menstrual Cycle

Age at first period	Frequency	Length
Pain ☐ Yes ☐ No	Clotting ☐ Yes ☐ No	Birth Control Use

Hormone Imbalance

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS ☐ PCOS

☐ Menopause Age at onset_____ Hormone Replacement Therapy_____

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MEN'S HEALTH HISTORY

☐ Prostate Enlargement ☐ Prostate Infection ☐ Prostate Cancer
☐ Difficulty with erection ☐ Change in urine stream ☐ Urination at night

DISEASES / DIAGNOSIS / CONDITIONS

Gastrointestinal

☐ Irritable Bowel Disease ☐ Inflammatory Bowel Disease ☐ Crohn's ☐ Ulcerative Colitis
☐ Gastric/Peptic Ulcer Disease ☐ GERD ☐ Celiac Disease ☐ H. Pylori
☐ Other_____

Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Irregular Heart Rate
☐ Heart Valve Disorders ☐ Decreased blood flow in legs ☐ Blood Clot ☐ Stroke
☐ Other_____

Metabolic / Endocrine

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypoglycemia ☐ Hypothyroidism ☐ Hyperthyroidism
☐ Weight Gain ☐ Weight Loss ☐ Eating Disorder
☐ Other_____
_____

Genital / Urinary

☐ Kidney Stones ☐ Gout ☐ Interstitial Cystitis ☐ Frequent UTIs ☐ Frequent Yeast Infections
☐ Other_____

Musculoskeletal / Autoimmune

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Sjogren's ☐ Lupus
☐ Fibromyalgia ☐ Immune deficiency disease ☐ Sepsis ☐ Chronic Fatigue Syndrome
☐ Other_____

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Respiratory

☐ Asthma ☐ Chronic Sinusitis ☐ Bronchitis ☐ Emphysema ☐ COPD
☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis
☐ Other_____

Skin

☐ Eczema ☐ Psoriasis ☐ Acne ☐ Melanoma ☐ Skin Cancer
☐ Other_____

Neurologic / Mood

☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐ ADD / ADHD
☐ Autism ☐ Headaches ☐ Migraines ☐ Memory Problems ☐ Tremor
☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ ALS ☐ Seizures
☐ Other_____

Sexual Health

☐ Herpes ☐ Hepatitis ☐ Syphilis ☐ Emphysema ☐ COPD
☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis
☐ Other_____

IMMUNIZATIONS

Did you receive all childhood vaccines? ☐ Yes ☐ No

Date last received of the following immunizations

Tetanus	Measles
Influenza	Pneumonia
COVID	Shingles
RSV	

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SUBSTANCE USE

Alcohol Use

Do you use alcohol? ☐ Yes ☐ No

How many drinks per week (1 drink = 5 ounces Wine; 12 ounces Beer; 1 shot)

- ☐ None
- ☐ 1-3
- ☐ 4-6
- ☐ 7-10
- ☐ more than 10

Have you ever been treated for alcohol abuse? ☐ Yes ☐ No

Tobacco Use

Do you use tobacco/nicotine? ☐ Yes ☐ No

What type of tobacco/nicotine?

- ☐ Chewing
- ☐ Cigarettes
- ☐ Cigars
- ☐ Vaping

How many years have you used tobacco? _____

How many packs per day? _____

If you quit using tobacco/nicotine, answer the following:

Years used_____

Packs per day_____

Are you exposed to second hand smoke? ☐ Yes ☐ No

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DRUG USE

Have you ever used any of the following?

- ☐ Marijuana
- ☐ Cocaine
- ☐ Methamphetamine
- ☐ Heroin
- ☐ Hallucinogens (Magic Mushrooms, PCP, LSD/Acid, etc.)
- ☐ Prescription medications not prescribed to you

Have you ever used IV drugs? ☐ Yes ☐ No

Have you ever been treated for drug abuse? ☐ Yes ☐ No

PSYCHOSOCIAL

Are you happy? ☐ Yes ☐ No

Do you ever feel hopeless? ☐ Yes ☐ No

Do you have any loss of interest/pleasure in things you once enjoyed? ☐ Yes ☐ No

Have you ever been in an abusive environment? ☐ Yes ☐ No

Do you have difficulty sleeping? ☐ Yes ☐ No

- ☐ Trouble falling asleep
- ☐ Waking up often during the night
- ☐ Use of sleep aids
- ☐ Snoring
- ☐ Hours slept per night_____

Have you eve been to counseling? ☐ Yes ☐ No

Have you ever been on medications for anxiety, depression, or any other mental health disease? ☐ Yes ☐ No

Have you ever self-harmed in any way? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

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CURRENT MEDICATIONS

Medication Name	Dose	Reason Taking

ALLERGIES

Medication Name or Substance	What Type of Reaction Did You Have?

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Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt(s)	Uncle(s)	Other
Age, if alive												
Age at death, if deceased												
Cancer												
Colon Cancer												
Breast/Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Autoimmune Disease e.g. Lupas												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Bipolar Disease												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Food Allergies, Sensitivities or Intolerances												

SYMPTOM REVIEW

Please check all current symptoms occurring in the past 6 months

GENERAL

- ☐Cold Hands & Feet
- ☐Cold Intolerance
- ☐Low Body Temperature
- ☐Low Blood Pressure
- ☐Daytime Sleepiness
- ☐Difficulty Falling Asleep
- ☐Early Waking
- ☐Fatigue
- ☐Fever
- ☐Flushing
- ☐Heat Intolerance
- ☐Night Waking
- ☐Nightmares
- ☐No Dream Recall

HEAD, EYES & EARS

- ☐Conjunctivitis
- ☐Distorted Sense of Smell
- ☐Distorted Taste
- ☐Ear Fullness
- ☐Ear Pain
- ☐Ear Ringing/ Buzzing
- ☐Eye Crusting
- ☐Eye Pain
- ☐Hearing Loss
- ☐Hearing Problems
- ☐Headache
- ☐Migraine
- ☐Sensitivity to Loud Noises
- ☐Vision Problems (Other than glasses)

MUSCULOSKELETAL

- ☐Back Muscle Spasm
- ☐Calf Cramps
- ☐Chest Tightness
- ☐Foot Cramps
- ☐Joint Deformity
- ☐Joint Pain
- ☐Joint Redness
- ☐Joint Stiffness
- ☐Muscle Pain
- ☐Muscle Spasms
- ☐Muscle Stiffness

Muscle Twitches:

- ☐Around Eyes
- ☐Arms or Legs

- ☐Muscle Weakness
- ☐Neck Muscle Spasm
- ☐Tendonitis
- ☐Tension Headache
- ☐TMJ Problems

MOOD/NERVES

- ☐Agoraphobia
- ☐Anxiety
- ☐Black-out
- ☐Depression

Difficulty:

- ☐Concentrating
- ☐With Balance
- ☐With Thinking
- ☐With Judgment
- ☐With Speech
- ☐With Memory

- ☐Dizziness (Spinning)
- ☐Fainting
- ☐Fearfulness
- ☐Irritability
- ☐Light-Headedness
- ☐Numbness
- ☐Other Phobias
- ☐Panic Attacks
- ☐Paranoia
- ☐Seizures
- ☐Suicidal Thoughts
- ☐Tingling
- ☐Tremor/ Trembling
- ☐Visual Hallucinations

EATING

- ☐Binge Eating
- ☐Bulimia
- ☐Can't Gain Weight
- ☐Can't Lose Weight
- ☐Poor Appetite
- ☐Salt Cravings
- ☐Carbohydrate Craving (breads, pastas)
- ☐Sweet Cravings (Candy, Cookies, Cakes)
- ☐Chocolate Cravings
- ☐Caffeine Dependent

DIGESTION

- ☐Bad Teeth
- ☐Bleeding Gums

Bloating of:

- ☐Lower Abdomen
- ☐Whole Abdomen
- ☐Bloating after meals

- ☐Blood in Stools
- ☐Burping
- ☐Canker Sores
- ☐Cold Sores
- ☐Constipation
- ☐Cracking at Corner of Lips
- ☐Cramps
- ☐Dentures w/Poor Chewing
- ☐Diarrhea
- ☐Alternating Diarrhea & Constipation
- ☐Difficulty Swallowing
- ☐Dry Mouth
- ☐Excess Flatulence/ Gas
- ☐Fissures
- ☐Foods "Repeat" (Reflux)
- ☐Gas
- ☐Heartburn
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Upper Abdominal Pain
- ☐Vomiting

Intolerance to:

- ☐Lactose
- ☐All Dairy Products
- ☐Wheat
- ☐Gluten (wheat, rye, barley)
- ☐Corn
- ☐Eggs
- ☐Fatty Foods
- ☐Yeast

- ☐Liver Disease/Jaundice
- ☐Abnormal Liver Function Tests
- ☐Lower Abdominal Pain
- ☐Mucus in Stools

SYMPTOM REVIEW *continued*

Please check all current symptoms occurring in the past 6 months

- ❒Periodontal Disease
- ❒Sore Tongue
- ❒Strong Stool Odor
- ❒Undigested Food in Stool

SKIN PROBLEMS

- ❒Acne on Back
- ❒Acne on Chest
- ❒Acne on Face
- ❒Acne on Shoulders
- ❒Athlete's Foot
- ❒Bumps on Back of Upper Arms
- ❒Cellulite
- ❒Dryness
- ❒Dark Circles Under Eyes
- ❒Ears Get Red
- ❒Easy Bruising
- ❒Lack of Sweating
- ❒Eczema
- ❒Hives
- ❒Jock Itch
- ❒Moles w/ Color/Size Change
- ❒Oily Skin
- ❒Rash
- ❒Red Face
- ❒Sensitive to Bites
- ❒Sensitivities to Poison Ivy/ Oak
- ❒Shingles
- ❒Skin Darkening
- ❒Strong Body Odor
- ❒Hair Loss
- ❒ Vitiligo

ITCHING SKIN

- ❒Skin in General
- ❒Anus
- ❒Arms
- ❒Ear Canals
- ❒Eyes
- ❒Feet
- ❒Hands
- ❒Legs
- ❒Nipples
- ❒Nose
- ❒Penis
- ❒Roof of Mouth
- ❒Scalp
- ❒Throat

LYMPH NODES

- ❒Enlarged/ Neck
- ❒Tender/ Neck
- ❒Other Enlarged/ Tender
- ❒Lymph Nodes

NAILS

- ❒Bitten
- ❒Brittle
- ❒Fungus/ Fingers
- ❒Fungus/ Toes
- ❒Pitting
- ❒Ridges
- ❒Soft
- ❒White Spots/ Lines

RESPIRATORY

- ❒Bad Breath
- ❒Cough
- ❒Hoarseness
- ❒Sore Throat

Hay Fever:

- ❒Spring
- ❒Summer
- ❒Fall
- ❒Change of Season

- ❒Nasal Stuffiness
- ❒Nose Bleeds
- ❒Post Nasal Drip
- ❒Sinus Fullness
- ❒Sinus Infection
- ❒Snoring
- ❒Wheezing
- ❒Winter Stuffiness

CARDIOVASCULAR

- ❒Angina/Chest Pain
- ❒Breathlessness
- ❒Heart Murmur
- ❒Irregular Pulse
- ❒Palpitations
- ❒Phlebitis
- ❒Swollen Ankles/ Feet
- ❒Varicose Veins

URINARY

- ❒Bed Wetting
- ❒Hesitancy (trouble starting)
- ❒Infection
- ❒Kidney Disease
- ❒Leaking/ Incontinence
- ❒Pain/Burning
- ❒Prostate Infections
- ❒Urgency

MALE REPRODUCTION

- ❒Discharge from Penis
- ❒Ejaculation Problem
- ❒Genital Pain
- ❒Impotence
- ❒Prostate or Urinary Infection
- ❒Lumps in Testicles
- ❒Poor Libido (sex drive)

FEMALE REPRODUCTION

- ❒Breast Cysts
- ❒Breast Lumps
- ❒Breast Tenderness
- ❒Ovarian Cyst
- ❒Poor Libido (sex drive)
- ❒Vaginal Discharge
- ❒Vaginal Odor
- ❒Vaginal Itch
- ❒Vaginal Pain with Sex

Premenstrual:

- ❒Bloating, Breast Tenderness
- ❒Carbohydrate Cravings
- ❒Chocolate Cravings
- ❒Constipation
- ❒Decreased Sleep
- ❒Diarrhea
- ❒Fatigue
- ❒Increased Sleep
- ❒Irritability

Menstrual:

- ❒Cramps
- ❒Heavy Periods
- ❒Irregular Periods
- ❒No Periods
- ❒Scanty Periods
- ❒Spotting Between Periods