1300 Woodland Ave

West Des Moines IA 50265

Ph: 515-280-3860

Fax: 515-309-0686

UCS Healthcare Medical History Form

Date:	
Legal name:	
Date of birth:	
Preferred name:	
Primary phone number:	
Pharmacy name & location:	

Please list any chronic medical problems:

1.	
2.	
3.	
4.	
5.	
6.	

List your current medications, including vitamins and supplements:

1.	
2.	
3.	
4.	
5.	
6.	

Do you have any other medical issues or medications? Please list.

Have you had surgery in the past? Please list those here.

Type of surgery	Date	Any issues?

Do you have any allergies? Please list the reaction and date of onset, if known.

Allergy	Date of onset	Reaction (what happens)

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Tobacco/nicotine use

- ❑ Vape only – how much/how often? ________________________
- ❑ Current tobacco user
  - o Packs per day____
  - o Cans or pouches of smokeless tobacco per day____
- ❑ Past tobacco user
  - o How many years?___
  - o When did you stop?___

Lifestyle - Tell us in general terms about your lifestyle.

How healthy is your diet?

- ❑ Not healthy
- ❑ Fairly healthy – could be better
- ❑ Healthy – I try my best
- ❑ Excellent

How often do you get at least 30 minutes of mild to moderate exercise?

- ❑ Never
- ❑ 1-3 times per month
- ❑ 1-3 times per week
- ❑ 4-6 times per week
- ❑ Daily
- ❑ Other:__________

On average, how many hours of sleep do you daily?

- ❑ Less than 4 hours
- ❑ 4-6 hours
- ❑ 6-8 hours
- ❑ More than 8 hours

On average, how much caffeine do you drink/eat daily? (this includes coffee, tea, soda, energy drinks, caffeine supplements) Please describe the number and type of caffeine you use.____

Do you use illicit drugs or prescription drugs in an illicit way? If yes, please describe the types of drugs and your frequency of use.

- ❑ Yes
- ❑ No

Please describe:

On average, how many servings of alcohol do you drink on a weekly basis? (1 serving is 5 oz of wine, 12 oz of regular beer, 1.5 oz of hard liquor)

- ❑ 0
- ❑ 1-3
- ❑ 4-7
- ❑ 8 - 14
- ❑ 15-21
- ❑ More than 21

Safety – Do you regularly use the following (if applicable)?

❑ Seatbelts	❑ Helmets	❑ Smoke detectors

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Family History

Condition	**Yes / Who**	**No**
Diabetes		
High blood pressure		
Cardiovascular Disease		
Cancer		
Stroke		
High Cholesterol		
Depression		
Anxiety		
Alcohol / Drug abuse		
Suicide		
Bipolar Disorder		

Additional comments about family history?

Social History

I identify as:

- ❑ Heterosexual
- ❑ Gay
- ❑ Lesbian
- ❑ Bi-sexual
- ❑ Pan-Sexual
- ❑ Polyamorous
- ❑ Transgender
- ❑ Other

My pronouns are:

- ❑ She /Her / Hers
- ❑ He /Him/HIs
- ❑ They /Them /Theirs
- ❑ Other

My Birth Sex ❑ Male ❑ Female
My Legal Sex ❑ Male ❑ Female
My Gender Identity:

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Relationship status

❑ Single ❑ Married ❑ Partnered ❑ Widowed

Do you feel safe at home?

❑ Yes ❑ No

Spouse/partner name (if applicable): ______________________________

Number of people in the household: __________

Children: ____

Comments: ____

Hobbies you enjoy: ____

Occupation:____

Immunizations

Name:	Date / Unknown
Influenza	
Tetanus / Tdap	
Varicella	
HPV	
Hep A	
Hep B	
Pneumonia	
Meningitis	
Shingles	
Pertussis / Whooping Cough	
MMR	
Other	

Past Screenings / Tests

Name	Date	Results
Cholesterol		
Colonoscopy		
Mammogram		
Pap		
Other:		

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History Overview

Many people experience violence in their lives, but never receive help as no one has asked them about it. We are here to help if you are in need of assistance. Please circle your answer:

Have you ever been in an abusive relationship? Y N

Does your partner ever hit you, hurt you, or threatened you in any way? Y N

Has your partner ever forced you to have sex when you didn't wat to? Y N

Are you afraid of your partner or anyone else in your life? Y N

Drugs and Alcohol can affect your medications and health outcomes.

In the last year, have you not remembered things that happened while you were drinking or using drugs? Y N

In the last year, have you ever drank or used more drugs than you intended to? Y N

Have you felt you wanted to change your patterns of drinking or drug use? Y N

Have you tried drank or used nonprescription drugs to deal with stress, frustration or other feelings? Y N

Have you been through any treatment programs in the past? Y N

Organ Donation

Are you an organ donor? Y N Would you like to be Y N

Advanced Directives

Do you have an advanced directive or living will? Y N

Who has power of attorney or is your designated medical decision maker if you should become incapacitated?

Review of body systems: Please circle any of the following you have / have had or are concerned about.

<u>General:</u>

Weight loss / Gain
Always hot or cold
Swollen glands
Other:

Increased thirst or urination
Dizziness
Obesity

Night sweats /hot flashes
Fatigue
Chronic pain

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Eye:

Glaucoma	Blurred vision	Dry / itchy	Glasses /contact
Cataracts	Loss of vision	Macular degeneration	General pain
Discharge			

Ear, Nose, Throat:

Hearing loss	Chronic Runny nose	Chronic stuffy nose	Dental or gum problems	Ear pain or drainage
Ringing in ears	Chronic bloody nose	Broken nose	Trouble swallowing	Frequent sore throat
Hay fever	Dentures	Voice change	Thyroid problems	

Breasts/Chest:

Lumps Tenderness Skin changes Nipple drainage

I complete monthly self-checks
- ❑ Yes
- ❑ No

Last mammogram:

Lungs:

Shortness of breath	COPD / Emphysema	Asthma	Wheezing	Coughing up blood
Daily chronic cough	Smoker	Tuberculosis	Excessive phlegm	Cancer
Other				

Heart:

Heart attack	High blood pressure	Chest pain	High cholesterol	Valve problems
Heart palpitations	Difficulty breathing	Leg cramps while walking	Irregular pulse	Waking up short of breath
Rheumatic fever	Ankle swelling	Other		

Gastrointestinal:

Change of appetite	Heartburn	Abdominal pain	Bloody or black stools	Difficulty swallowing
Ulcers	Diverticulitis	Hemorrhoids	Diarrhea	Constipation
Anal pain	Nausea / vomiting	Crohn’s	Colitis	Other

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Neurology:

Headaches / Migraines	Tremors	Paralysis	Seizures
Strokes / TIA	Dementia	Neuropathy	Memory loss
Fainting/ dizziness / passing out	Alzheimer's		

Mental Health:

Depression	Anxiety	Panic attacks	Bipolar	Schizophrenia
Hallucinations	Past assault / trauma	Suicidal thoughts /attempts	Eating disorders	Chemical dependency
Insomnia	PTSD	Other		

Musculoskeletal:

Neck pain	Back pain	Muscle pain	Nighttime leg cramps	Joint problems
Brace or splint use	Osteoporosis	Fractures	Joint replacement	Fibromyalgia
Other				

Skin:

Eczema	Acne	Psoriasis	Moles	Excessive dryness
Other				

Urinary, Kidney:

Chronic UTI	Kidney Stones	Difficult / painful urination	Blood in urine	Bladder stones
Frequent urination at night	Other			

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Sexual health:

Do you have or have you had any sexually transmitted diseases? (STDs) ❑ Yes ❑ No	Currently sexually active? ❑ Yes ❑ No	On birth control? ❑ Yes ❑ No	Follow safer sex guidelines? ❑ Yes ❑ No
If yes, list those STDs:	Current sexual partners: ❑ Male ❑ Female	❑ Transman ❑ Transwoman	

Penis:

Pain or lump in testicle	I do testicle self-exams ❑ Yes ❑ No	Hernia	Prostate problems	Painful intercourse
Difficulty getting erection	Inability to ejaculate	Premature ejaculation	Sores	Other

Vaginal:

Heavy flow	Dryness	Painful cramps	Orgasm difficulty	Sores
Irregular period	History of abnormal pap	Painful intercourse	Discharge	
Age of first period___	Days between periods___	Length of average period___	Date of most recent pap ___	
# of still births ___	# of Abortions___	# of Miscarriages___	# of pregnancies___	# of Live births___

Is there anything else you would like us to know about your health or your child's health?

In order to keep our records current and provide optimal care, please let us know if there are any changes to this information at each appointment. Thank you for allowing us to serve your healthcare needs.

TJ Guthrie, ARNP David Huante, MD LeeAnn Albright, ARNP Sarah Fett, ARNP

Mollie O'Brien, ARNP Frank Filippelli, DO Joshua Tessier, DO