MEDICAL GROUP
Part of Optum®

2 S Cascade Ave, Colorado Springs, CO 80903 • (719) 590-1177 • www.MVMG.com

Medical History Form

(This form is NOT to be used for OB/Gyn patients)

Basic Information

Date: ___________________________

Name: ___________________________

DOB: ___________________________

Office Location: ___________________________

List ALL current medications/herbal with directions and dosage of each listed:

List ALL allergies and types of reactions:

Current Medical History

Please check if applicable

- ☐ Healthy, No past/present medical problems
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar
- ☐ Bone Fracture – Location___________
- ☐ Cancer – Type____________________
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Eating Disorder
- ☐ Eye Problems
- ☐ Febrile Seizure
- ☐ Gastroesophageal Reflux
- ☐ Other____________________________
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Motor Vehicle Accident with Injuries
- ☐ Recurrent Ear Infections
- ☐ Stroke
- ☐ UTI/BladderInfection/KidneyInfection – Recurrent
- ☐ UTI/Bladder Infection/Kidney Infection – under age 5 years

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Past Surgical History

Please check if applicable

- ☐ No History of Previous Surgeries
- ☐ Abdominal Surgery – Type___________
- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Bronchoscopy
- ☐ Ear/Nose/Throat Surgery
- ☐ Eye Surgery
- ☐ Bladder Surgery
- ☐ Gallbladder Surgery
- ☐ Gynecological Surgery
- ☐ Other ______________________________
- ☐ Heart Surgery
- ☐ Hernia Repair – Inguinal
- ☐ Hernia Repair – Umbilical
- ☐ Joint Replacement – Type__________
- ☐ Joint Surgery – Type______________
- ☐ Kidney/Bladder Surgery
- ☐ Patent Ductus Arteriosis Repair
- ☐ Tonsillectomy
- ☐ Tubes in Ears
- ☐ Vascular Surgery/Stent Procedure

Family History

Please check if applicable

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Coronary Heart Disease
- ☐ Coronary Heart Disease Male under 55
- ☐ Coronary Heart Disease Female under 65
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Stroke
- ☐ Hypertension
- ☐ Lung Cancer
- ☐ Melanoma
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Renal Disease
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Suicide
- ☐ Thyroid Disease
- ☐ Huntington's Chorea
- ☐ Learning Disabilities
- ☐ ADD/ADHD
- ☐ Other

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Social HIstory

Please complete the following questions

Pediatric (Newborn to 17 years old)

Parent/Guardian Name: ______________________

Siblings Names/DOB: ______________________

School Name: ______________________ Grade: __________

Has this child been exposed to any domestic violence? ☐ Yes ☐ No

Are there any religious beliefs that affect this child's care? ☐ Yes ☐ No

Is this child in foster care? ☐ Yes ☐ No

Are the parents of this child divorced or separated? ☐ Yes ☐ No

Does this child live with grandparents? ☐ Yes ☐ No

Was this child adopted? ☐ Yes ☐ No

Is this child exposed to ANY passive smoking? ☐ Yes ☐ No

Are this child's vaccines completely up to date? ☐ Yes ☐ No

If known please provide the following:

Birth Weight __________ Gestational Age __________

Pregnancy or Postnatal Complications ______________________

Adult (18 years old and up)

Marital Status: Single Married Separated Divorced

Number of Pregnancies ______ Number of Births __________

Occupation ______________________

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Health Maintenance Form

Please supply most recent date for each of the following, if you have had them done in the past.
Please bring a copy of all shot records, test results, last EKG, etc. with you to your appointment. (If you have them)

Health Maintenance Value	Date Completed	Location Completed
Colonoscopy	______________	______________________________
EKG	______________	______________________________
Pap Smear	______________	______________________________
Physical Exam	______________	______________________________
Radiology		
Chest X-Ray	______________	______________________________
Mammomgram	______________	______________________________
Vaccines		
Flu	______________	______________________________
Pneumonia	______________	______________________________
Shingles/Zostavax	______________	______________________________
Tetanus	______________	______________________________
Tetanus with Pertussis	______________	______________________________
Labs		
Cholestrol	______________	______________________________
Hgb A1c	______________	______________________________
PSA	______________	______________________________
Thyroid	______________	______________________________

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Health Maintenance Form

Name: ______________________________ Date of Birth: __________ ____________________

Tobacco Use (All forms of tobacco):

☐ Current Every Day User:

☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless

#Packs per day _______ # years using _______ #Cans per day _______

☐ Current Some Day User

☐ Never Used

☐ No Longer use Tobacco

Year Quit _______ #Packs per day _______ #years using _______

What type of tobacco did you use? ______________________________

Passive exposure?/ Are you exposed to tobacco users? ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No

If yes list substance ______________________________

Possible HIV Exposure: ☐ Yes ☐ No

Have you: ☐ Had more than 10 sexual partners in your life

☐ Used IV drugs

☐ Had a blood transfusion before 1987

☐ Had exposure to someone with HIV

Caffeine Usage: # Drinks per day _______

Family History of Heart Attacks in females less than 65 years of age? ☐ Yes ☐ No

Family History of Heart Attacks in males less than 55 years of age? ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No

Drink Alcohol daily? ☐ Yes ☐ No

Drinks per day _______ Type of Alcohol ______________________

Have you ever felt the need to cut down? ____________________

Been annoyed by complaints of your drinking? ________________

Felt guilty about your drinking? ____________________________

Need an eye opener in the morning? _________________________

Exercise: Do you exercise: ☐ Yes ☐ No

What type of exercise? ________________ #Times per week ________________

Seat Belt Usage: Percent of time ☐ 100 ☐ 75 ☐ 50 ☐ 25

Sun Exposure: ☐ Frequent ☐ Occasionally ☐ Rarely