OPTUM Care™
Medical Group

MEDICAL HISTORY FORM

Name: _____ Date of birth: _____ Today's date: _____

Local pharmacy name: _____ Mail order pharmacy name: _____

Address: _____ Mail order pharmacy fax: _____

Phone: _____

Medications ❒ I do not take any medications

(Include prescription, over-the-counter medication, birth control, vitamins, herbal supplements)

Medication name	**Dose**	**Frequency (how many and how often)**

Allergies (List all known allergies (drug, food, etc.) and reaction ❒ No known allergies

_____

_____

Chronic medical problems/year of onset

	Year		Year		
❒ Heart disease/heart attack		❒ Asthma		❒ Other:	
❒ High blood pressure		❒ Allergies/hay fever			
❒ High cholesterol		❒ Vascular disease			
❒ Diabetes		❒ Depression			
❒ Cancer (list type and treatment)		❒ Anxiety			

Prior surgeries and hospitalizations / year

_____ _____

_____ _____

Family history

Please check if any family member has had any of the following conditions: ❒ Unknown ❒ Adopted

Family Member	Good health	Heart disease (Age of onset)	Hypertension (Age of onset)	Stroke (Age of onset)	Cancer (& Type) (Age of onset)	Other Illness (Age of onset)
Father						
Mother						
Sibling						
Grandfather/ Grandmother						
Other:						

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MEDICAL HISTORY FORM (Continued)

Name: _____ Date of birth: _____

Social history

1. Please briefly describe your occupation:

_____

2. Please briefly describe your living situation, i.e who lives in your house/apartment and relationship to you:

_____

3. Tobacco use: ❒ Never ❒ Current ❒ Former Cigarettes/day: _____ Years used: _____ Year quit: _____

   • If you are currently smoking, are you ready to quit? ❒ Yes ❒ No

4. Alcohol use: ❒ Yes ❒ No ❒ Former Amount: _____ How often: _____

5. Excercise/ activity ❒ Yes ❒ No Type: _____ How often? _____ Hours per week? _____

6. Do you have an advance directive? (These allow a patient to state choices for health care and name someone to make choices if he or she is unable to do so)

❒ None ❒ Advanced Health Care Directive ❒ POLST ❒ Living Will

Confidential information

Recreational drugs: ❒ No ❒ Yes ❒ Former ❒ Drug Type/Frequency _____

Do you have concerns for your safety? _____

Preventative medicine

Please list other physicians/health care providers you see (and the reason you see them)

_____ _____

_____ _____

_____ _____

Please list the last time you received the services below

Health maintenance exam	Year	Immunizations	Year
❒ Mammogram		❒ HPV (Gardasil)	
❒ Pap smear		❒ Tetanus/Whooping cough (Tdap)	
❒ Colonoscopy		❒ Influenza (Flu)	
❒ Bone density		❒ Shingles (Zostavax)	
❒ Eye exam		❒ Pneumonia (Pneumovax)/Prevnar 13	
❒ Dental exam		❒ PPD (Tuberculosis skin test)	
❒ FloChec		❒ PPD positive ❒ PPD negative	
❒ Spirometry		❒ MMR	

Reviewed by: _____ **Date:** _____

Provider's signature

❒ Check if scanned into PAQ