MedicalCenter Clinic
HEALTHCARE CENTERED AROUND YOU

Infectious Disease History Form

Name ____________________ Date of Birth_______________ ☐Single ☐Married ☐Divorced ☐Widow (er)

Address____ Religion _______________________

Occupation_________________ Previous Occupations ________________ Occupation of Spouse_________________

Birthplace______________________________ List all States or Countries in which you have lived______________________

Education: Please check the last grade you completed

Grade	☐5	☐6	☐7	☐8
High School	☐1	☐2	☐3	☐4
College	☐1	☐2	☐3	☐4
Post Grad.	_________________________ yrs.			
Degrees	_________________________			

Have you traveled outside the USA in the last year?______________________Where?_________

Reason for today's appointment:____

Were you referred to the clinic?_______ If so, by whom (name and address)?________________

Family History:

	Age	Health	Age at Death	If deceased cause
Father				
Mother				
Brothers/Sisters				
1.				
2.				
3.				
4.				
Husband/Wife				
Son or Daughter				
1.				
2.				
3.				
4.				
5.				
6.				

Do you have any blood relatives who have any of the following conditions?

☐ cancer (type___) ☐ Tuberculosis ☐diabetes ☐Heart Trouble

☐high blood pressure ☐ stroke ☐Epilepsy ☐mental illness

☐suicide ☐birth defects ☐Thyroid Disease ☐Alcoholism

Personal History (Please check all that apply):

- ☐ measles or German Measles
- ☐ Chicken pox or mumps
- ☐ Whooping cough
- ☐ Scarlet fever or Scarletina
- ☐ Migraine headaches
- ☐ Stroke or paralysis
- ☐ blindness (even temporary)
- ☐ seizures or epilepsy
- ☐ Meningitis or polio
- ☐ pneumonia or pleurisy
- ☐ tuberculosis (TB)
- ☐ asthma
- ☐ Influenza or flu
- ☐ Hayfever
- ☐ Hives or eczema
- ☐ heart attack
- ☐ Angina
- ☐ heart failure
- ☐ Rheumatic fever or heart murmur
- ☐ high blood pressure
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ diabetes
- ☐ Ulcers (stomach/intestinal)
- ☐ hepatitis
- ☐ gallbladder disease
- ☐ Hiatus hernia
- ☐ Diverticulosis
- ☐ Kidney/urinary tract infections
- ☐ Venereal Disease
- ☐ Gonorrhea or Syphilis
- ☐ Arthritis or Rheumatism
- ☐ Bursitis, Sciatica, Lumbago
- ☐ Neuritis or Neuralgia
- ☐ Anemia
- ☐ Unusual bleeding/bruising
- ☐ Poisoning (food, chemicals, drugs)
- ☐ Thyroid Disease or Goiter
- ☐ X-ray Therapy or Radiation
- ☐ Nervous Breakdown
- ☐ Severe Depression
- ☐ Frequent sore throats
- ☐ Frequent infections
- ☐ Any other Disease

Have you ever been immunized for:

Diphtheria………. …Yes No when?_____________________

Tetanus………. ……Yes No when?_____________________

Polio………………. Yes No when?_____________________

German Measles…. Yes No when?_____________________

Pneumonia…...…. …Yes No when?_____________________

Influenza……… ……Yes No when?_____________________

Measles……………. Yes No when?_____________________

Whooping Cough…. Yes No when?_____________________

Have you ever had a skin test for TB (tuberculosis)?_______________________ When?_______________

ALLERGIES (Are you allergic to):

- ☐ Latex
- ☐ Penicillin or Keflin
- ☐ Sulfa
- ☐ Erythromycin or Tetracycline
- ☐ Other antibiotics
- ☐ Aspirin or Tylenol
- ☐ Codeine or Morphine or Demerol
- ☐ other pain medication
- ☐ Valium or Librium
- ☐ Phenobarbital
- ☐ Dalmane or Seconal
- ☐ other tranquilizer
- ☐ Iodine, Merthiolate or Mercurochrome
- ☐ Betadine or pHisoHex
- ☐ Antihistamines
- ☐ any other drug
- ☐ any food
- ☐ Adhesive tape

☐ Cosmetics or perfume ☐Nail polish ☐Any other immunizations

☐Any other serums

INJURIES (have you had any):

☐Broken bones ☐Sprains or dislocations ☐Lacerations (Extensive)

☐ Concussion or head injury ☐Ever been knocked out ☐Whiplash

TRANSFUSIONS (have you had any):

☐Blood or Plasma transfusion

WEIGHT:

Now ___________________________

One Year Ago ___________________________

Maximum ___________________________ (year___________________________)

HOSPITALIZATIONS:

Surgical Hospitalizations

1. Tonsillectomy ☐ Yes ☐No
2. Appendectomy ☐ Yes ☐No
3. Any other surgery (please list)

____
____
____
____

HOSPITALIZATIONS other than for surgery (please list):

____
____
____
____

Habits: Do you

1. Sleep well?..Yes No

2. Use alcoholic beverages?....................................Yes No

Every Day………………………………….Yes No

3. Smoke? ....Yes No

How much?___________________________________

4. Exercise enough?..Yes No

5. Is your diet well balanced? ....Yes No

MEDICATIONS: List any drug or medication that you take.

____
____
____
____
____
____
____

WOMEN ONLY:

1. Age at onset of menstruation____________________________

2. Date of last period_____________________________________

3. Is it possible that you may be pregnant? Yes No

4. Menstrual cycle _____________________days (from start to start)

5. Cycle ☐ regular ☐irregular

6. Usual duration of flow_________________days

7. Flow: ☐ Heavy ☐Medium ☐Light

8. Cramps ☐ Severe ☐Mild ☐None

9: Pregnancies: How many?___________________

Children born alive? ___________________

Stillbirths? ___________________

Prematures? ___________________

Cesarean sections? ___________________

Miscarriages? ___________________

Complications? Yes No

____ ____

Patient's Signature Date