St. Matthew's Medical Clinic Health History

Medical Allergies:

Other allergies:

Past or present medical conditions: (Check all that apply)

asthma___ pneumonia/bronchitis___ COPD/emphysema___
shortness of breath___ stroke___ headaches___
heart disease___ (specify):
chest pain___ high cholesterol___ hypertension/high blood pressure___
anemia dizziness/fainting___ seizure disorder/epilepsy/convulsions___
GI disorder___ (specify):
gallbladder disease___ hepatitis___ bowel changes/rectal bleeding___
diabetes___ thyroid disease___ prostate disease___
kidney disease___ cancer___ (specify):
psychological diagnosis___ (specify): (example bipolar/anxiety/depression)
other medical conditions:

Hospitalizations: (please print)

Date	Surgery/procedure/reason for hospitalization

Immunizations and date:

Flu shot___ pneumonia___ tetanus___ hepatitis B___

Health Habits:

Tobacco use: current___ smoke___ chew___ vape___ former___ when did you quit?
Marijuana use: how many times daily?

Drug use:

Alcohol use: never___ daily___ weekly___ occasionally___ 1-2 drinks___ 3-4 drinks___ greater than 5 drinks___
Exercise: How often/long to you exercise? (example twice a week for 30 minutes)

Family Medical History: (please print)

Condition	Family member(s)	Condition	Family member(s)
Heart disease		High blood pressure	
Stroke		Diabetes	
Seizures/epilepsy		Glaucoma	
Kidney disease		Blood disorder	
Mental illness		Thyroid disease	
Cancer		GI disease	

Name: DOB: Today's date: