MHC Healthcare
Quality healthcare with a heart!

Name____ Date_________
DOB________________

The completion of this form enables MHC Healthcare to provide you with a higher quality of medical care
Please Check any and all conditions/illnesses and surgeries that pertain to you.

Medical History

- ☐ None
- ☐ Memory Loss
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ PTSD
- ☐ Suicidal attempts
- ☐ Psychiatric Hospitalizations
- ☐ Traumatic Brain Injury
- ☐ Stroke
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Blindness
- ☐ HYPOthyroidism
- ☐ HYPERthyroidism
- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis
- ☐ Pulmonary Embolism (Clot in Lungs)
- ☐ DVT (Clot in legs/other)
- ☐ Heart Disease / Attack
- ☐ High Blood Pressure
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Heart Valve Disease
- ☐ Reflux/GERD
- ☐ Ulcers
- ☐ Deafness
- ☐ Crohn's Disease
- ☐ Celiac Disease
- ☐ Lupus
- ☐ Diabetes Type:__________
- ☐ Diabetes during pregnancy
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Chronic Pain
- ☐ Urinary Incontinence
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Cancer:_____________
- ☐ Chemotherapy/Radiation
- ☐ Seizures
- ☐ Abnormal Pap Smear
- ☐ Enlarged Prostate
- ☐ Prescription Drug Abuse
- ☐ Varicose Veins
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Kidney Stones
- ☐ HIV
- ☐ Sexually Transmitted Disease (STD)
- ☐ Cirrhosis
- ☐ Fatty Liver
- ☐ Hepatitis B_____ C_____
- ☐ Colon polyps
- ☐ Other:________________________

Past Surgeries

- ☐ None
- ☐ Tonsils Removal
- ☐ Thyroid Surgery
- ☐ Appendix Removal
- ☐ Gallbladder Removal
- ☐ Weight Loss Surgery Type____________
- ☐ Open Heart Surgery
- ☐ Stents in Heart
- ☐ Pacemaker
- ☐ Heart Valve Replacement
- ☐ Back Surgery
- ☐ Sexual Reassignment
- ☐ Breast Surgery
- ☐ Carpal Tunnel
- ☐ Brain Surgery
- ☐ Eye Surgery (laser, cataracts, etc.)
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Plastic Surgery:______________
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Cesarean Section
- ☐ Colon Resection
- ☐ Prostate Surgery
- ☐ Other______________________

Family History: Please Check if it Runs in Family

	Father	Mother	Children	Siblings
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐

Marital Status: ☐Single ☐Married ☐Widow ☐Divorced

Education: ☐Elementary ☐Secondary ☐College ☐Post Graduate

Occupation: ______________________________
☐Full Time ☐Part Time ☐Retired ☐Unemployed

Sexual Orientation: ☐Straight (not lesbian or gay) ☐Lesbian or Gay ☐Bisexual ☐Other: ___________ ☐Do Not Know ☐Choose Not to Discuss

Gender Preference: ☐Male ☐Female Transgender: ☐Female to Male ☐Male to Female

Sex Assigned at Birth: ☐Male ☐Female ☐Decline to Answer

Preventive Medicine: Please provide date of most recent test, as well as, location where it was performed if known.

	Date:	Location:
Colon Cancer Screening:	_________	___________________
Pap Smear	_________	___________________
Mammogram	_________	___________________
DEXA/Osteoporosis Test	_________	___________________
Tetanus Vaccine	_________	___________________
Pneumonia Vaccine	_________	___________________
Flu Vaccine	_________	___________________

Social: Please answer all questions

	Never	Past	Current
Tobacco Use:			
Cigarettes	☐	☐	☐
Chew	☐	☐	☐
Vaping	☐	☐	☐
Alcohol Use:			
Beer	☐	☐	☐
Wine	☐	☐	☐
Liquor	☐	☐	☐
Substance Use:			
Marijuana without Prescription	☐	☐	☐
Heroin	☐	☐	☐
Cocaine	☐	☐	☐
Methamphetamine	☐	☐	☐
Other:	☐	☐	☐
Intravenous Use?	☐	☐	☐

Diet: ☐Regular ☐Vegan ☐Vegetarian Gluten-Free ☐Low Carb ☐Low Fat
Exercise: ☐ Yes ☐ No # Times Per Week___________
Type:________________________

Allergies: (**Medications, Food, Others)**

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____

Current Medications: (Prescribed, Over the Counter, Vitamins, Medical Marijuana with Card, etc.)

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Other Doctors/Specialists: (Cardiology, ENT, etc)

Name of Provider or Group	Specialty	Location

Patient Signature:____ **Date:** ____________