MIDC
METRO INFECTIOUS DISEASE CONSULTANTS

PATIENT HISTORY

Date: _____

Name: _____ DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Preferred mode of communication (check one):

☐ Home Telephone #: _____ OK to leave message? ☐ Yes ☐ No

☐ Cell Telephone #: _____ OK to leave message? ☐ Yes ☐ No

☐ Email: _____ OK to leave message? ☐ Yes ☐ No

Emergency Contact: _____ Phone #: _____

Pharmacy Name, Address, and Phone #: _____

Ethnicity: _____ Race: _____ Language: _____

Employer: _____

Address: _____ Phone: _____

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Provider _____ Reason for Visit: _____

☐ Please enroll me in the patient portal. My email is: _____

☐ I decline enrollment for the patient portal

ALLERGIES *(check all that apply):*

☐ No known allergy
☐ Peanuts
☐ Avocado
☐ Chocolate
☐ Eggs
☐ Wheat/Gluten
☐ Licorice
☐ Milk
☐ Nuts
☐ Strawberries
☐ Seafood/Shellfish
☐ Soy
☐ Grass
☐ Pollen
☐ Mold
☐ Cat
☐ Dog
☐ Animal Dander

DRUG ALLERGIES (please list)

_____
_____
_____
_____
_____

LATEX ALLERGY? ☐ Yes ☐ No

MEDICATIONS *(please list ALL medications with dosage and frequency):*

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____
4. _____ Dosage: _____ Frequency: _____
5. _____ Dosage: _____ Frequency: _____
6. _____ Dosage: _____ Frequency: _____
7. _____ Dosage: _____ Frequency: _____
8. _____ Dosage: _____ Frequency: _____
9. _____ Dosage: _____ Frequency: _____
10. _____ Dosage: _____ Frequency: _____

Last Flu Vaccine _____

Last Pneumococcal Vaccine _____

MEDICAL HISTORY *(check all that apply):*

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ CHF
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Peripheral Neuropathy
- ☐ Pneumonia
- ☐ Seizures
- ☐ STD's
- ☐ Stroke _____
- ☐ TB Exposure/IB
- ☐ Toxoplasmosis
- ☐ UTI
- ☐ Varicella _____

SOCIAL HISTORY *(check all that apply):*

- ☐ Special Diet — Restrictions: _____
- ☐ Tobacco Use — Frequency (packs/day): _____
- ☐ Alcohol Use — Frequency (drinks/day): _____
- ☐ Drug Use — Type and Frequency: _____
- ☐ Caffeine Use — Frequency (cups/day): _____
- ☐ Exercise — Frequency (activity; times/week): _____

INSURANCE INFORMATION:

Subscriber Name: _____ Date of Birth: _____

Insured Name: _____ Date of Birth: _____

FAMILY HISTORY

Blood Disorder	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Diabetes	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Cancer	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Seizures	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Drug Abuse	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Alcohol Abuse	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Tuberculosis	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Heart Disease	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Stroke	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Hypertension	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Hyperthyroidism	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Hypothyroidism	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Obesity	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Thyroid Disease	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____
Other	☐ None	☐ Self	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Type: _____

Any mortalities from above conditions? Note any relevant information, issues, and age of death.

_____

_____