Boulder Community Health
Ambulatory Services Department

Medical History Questionnaire – Beacon Center

Name:	**DOB:**
Reason for Visit:	
Primary Care Physician:	

Past Medical History - Please check √ all that apply

☐ Chickenpox	☐ Surgical Infection:	☐ *Heart Disease (list):*
☐ Rheumatic Fever	☐ Clostridium difficile	☐ Coronary Artery Disease
☐ Mononucleosis	☐ UTI/recurrent UTI	☐ Valve Disease
☐ Herpes Simplex	☐ Prostate infection	☐ High Blood Pressure
☐ Trichomonas	☐ Lyme Disease	☐ Congestive Heart Failure
☐ Chlamydia	☐ Other:	☐ Elevated Cholesterol
☐ Gonorrhea	☐ Other:	☐ Diabetes
☐ Syphilis	**General Medical Problems**	☐ *Kidney Disease (list):*
☐ HIV/AIDS	☐ *Autoimmune Disorder (list):*	☐ Hemodialysis
☐ Hepatitis A		☐ *Liver Disease (list):*
☐ Hepatitis B	☐ *Blood Disorder (list):*	☐ Cirrhosis
☐ Hepatitis C	☐ Blood Clots/DVT/PE	☐ *Lung Disease (list):*
☐ Pneumonia	☐ *Bowel (GI) Disease (list):*	☐ COPD
☐ Tuberculosis	☐ GERD/Acid Reflux	☐ Asthma
☐ Cellulitis/skin infection	☐ H. Pylori	☐ *Rheumatologic Disorder (list):*
☐ MRSA	☐ *Thyroid Disease (list):*	☐ Lupus
☐ Abscess	☐ Depression/Anxiety	☐ Rheumatoid Arthritis
☐ Joint Infection:	☐ Drug/Alcohol Abuse	☐ Scleroderma
☐ Bone Infection:	☐ Bipolar disorder	☐ *Cancer (list):*
☐ Spine Infection:	☐ Chronic Pain	☐ *Cancer (list):*
☐ Blood Infection:	☐ Gout	☐ *Transplant (list):*
☐ Heart Infection:	☐ Glaucoma	☐ Other:
☐ Fungal Infection:	☐ *Skin Disease (list):*	☐ Other:

List Recent International Travel:

Hospital Admissions/Surgeries

Year	Description

Current Medications			
Medication	Dose	Medication	Dose

Birth Control Method (if not listed above):

DRUG ALLERGIES & REACTIONS	Vaccines	Year(s) given
	Flu Vaccine	
	Pneumonia Vaccine	
	Hepatitis A or B (circle)	
	Tetanus/Tdap/Pertussis	
	MMR (Measles, Mumps, Rubella)	
	Varicella (Chicken Pox)	
	HPV	
	Other: (Specify)	

Family History

Have any of your close relatives had any of the following conditions?

Condition	Type	Relation to you	Maternal/Paternal	Age Diagnosed
☐ Blood Disorder				
☐ Cancer				
☐ Diabetes				
☐ Heart Disease				
☐ High Blood Pressure				
☐ Stroke				
☐ Kidney Disease				
☐ Lung Disease				
☐ Other:				

Social History

Feels safe at home	☐ Yes	☐ No	Caffeine	☐ Yes	☐ No
Seatbelts used	☐ Yes	☐ No	Tea/Coffee_____cups/day		
Hearing aids	☐ Yes	☐ No	Colas_____cans/day		
Vision Impaired	☐ Yes	☐ No	Tobacco	☐ Yes	☐ No
HIPAA Privacy available	☐ Yes	☐ No	Never ☐ | Former ☐ Quit date_____		
Speak up brochure available	☐ Yes	☐ No	Current #/type per day_____		
			Exercise	☐ Yes	☐ No
Alcohol - Drinks/week_____	☐ Yes	☐ No	Activity per week:_____		
Street Drugs	☐ Yes	☐ No	Sexually active	☐ Yes	☐ No

Signature:_____ Date:_____