ProHEALTH Care

PART OF OPTUMCARE

Name:______________________

## MEDICAL HISTORY

CHECK ANY CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Blood Clot / DVT
- ☐ Cancer Type_____
- ☐Osteoarthritis
- ☐ Cataract
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur / Palpitations
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Lyme Disease
- ☐ Mental Disorder
- ☐ Phlebitis
- ☐ Rheumatoid Arthritis
- ☐ Seizures or Epilepsy
- ☐ Sleep Apnea
- ☐ Stroke / TIA
- ☐ Thyroid Disease
- ☐ Ulcer

Please list other medical problems/ hospitalizations you have/had:

1.________________________________________ Date:______
2.________________________________________ Date:______
3.________________________________________ Date:______

**FAMILY HISTORY:**

Does anyone in your immediate family suffer/suffered from any medical conditions? ☐ Yes ☐ No

If so, ____________________Relationship:_______ Age: ___ Deceased Date:_____

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PLEASE LIST ALL MEDICATIONS / DOSAGE / FREQUENCY:

1.____________________ 6.____________________
2.____________________ 7.____________________
3.____________________ 8.____________________
4.____________________ 9.____________________
5.____________________ 10.___________________

Please list if you are on a Blood Thinning Agent or Immunosuppressant Drug: ____________

Have you had any surgery/ injuries in the past? ☐ Yes ☐ No

Please List: ________________________________________

______________________________________________

Allergies: ________________________________________

Are you pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, how much? ________________

Do you drink alcohol? ☐ Yes ☐ No Any substance use or abuse? ☐ Yes ☐ No _______

If yes, how much: ☐ Rarely ☐ Socially ☐ 1 drink/day ☐ 2-3 drinks/day ☐ 4 drinks or more/day

Are you currently working? ☐ Yes ☐ NO If not, when did you last work? ____________