Flathead Valley Community College

Student Health Clinic

Medical History Form

Welcome to the Flathead Valley Community College Student Health Clinic. In our attempt to provide efficient care for you at your appointment, we encourage you to fill out this form prior to your visit with the provider. Thank you.

Patient Name: _____ Date of Birth: _____

Ethnicity:_____ Male/Female/Transgender (circle)

Past Medical History

- Weight loss / gain
- Vision problems
- Hearing problems
- Headaches
- Heart problems
- Blood clot or stroke
- High Blood pressure
- High Cholesterol
- Asthma
- Lung problems
- Stomach/intestinal problem
- Colon problems
- Thyroid problems
- Diabetes
- Liver problems
- Kidney/urinary problems
- Muscle/bone/joint problem
- Skin problem
- Depression/mental health problem
- Eating disorder
- Hereditary disease
- Neurological problems/seizures
- Anemia
- Cancer
- Sexually transmitted diseases
- Other

Describe any of the checked problems:

_____

_____

Primary Care Provider/Regular Doctor: _____

Allergies

Food/Environmental/Drug allergies: Reaction:

_____

_____

_____

Medications

Name of Medications: Strength/Dose: When do you take this medication each day?

_____

_____

_____

Surgical History

Please list past surgeries: Dates: Location: Reason:

_____

_____

_____

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Family Medical History

Please indicate relationship: M= Mother, F= Father, S= Sister, B= Brother, C= Child
MGM= Maternal (mother's side) grandmother, MGF = maternal grandfather,
PGM= Paternal (father's side) grandmother, PGF= Paternal grandfather

Diabetes _____
High Blood pressure_____
Heart Disease _____
Lung Problems_____
Other Problems:

Cancer_____
Colon Problems_____
Blood clots_____
Stroke_____

Thyroid problems _____
Mental Health _____
Substance abuse_____

_____
_____

Social History

Alcohol / Tobacco exposure: Do you smoke or vape? _____
If yes, how many packs/cartridges per day? _____ Number of years that you have smoked/vaped? _____
Do you use chewing tobacco? _____ How many cans per week? _____
Do you or have you ever used street drugs? _____
Number of alcoholic drinks per week/day: _____
Are you sexually active? _____ Sexual Orientation (optional)_____
Exercise information: Do you exercise regularly? _____What type and how often? _____
_____
Occupation: _____ Religion (optional): _____
Who do you live with? _____ Marital status: _____
Do you feel safe at home? _____

If Female

Date of last period: _____ Date of last Pap smear: _____
Birth Control Method: _____
Any abnormal Pap Smears and when? _____ If so, was the following one normal? _____
Date of last mammogram: _____ Any abnormal mammogram? _____ Age at Menopause:_____
Obstetric History:
Number of Pregnancies: _____ Number of Living children: _____ Number of Miscarriages: _____
Number of Abortions: _____