Mankato Clinic

PLEASE ANSWER EACH ITEM

«PName»	DOB: «PDOB»
Pat #: «PNumber»	Age: «PAge»
Date: «ApptDate»	Time: «appttime»
Res: «ApptResDesc»	

Occupation:	
Please Circle Single Married Divorced Widowed	
Gender Identity	
Gender Transition	**Type** (M to F or F to M):
Yes No	**I Am Adopted**
Yes No	**I have access to medical history**

SMOKING, VAPING & TOBACCO USE					
	Yes No	Current Use	Product	How many years?	How much per day?
	Yes No	Former Use	Product	How many years?	When did you quit?

MY HEALTH INFORMATION & FAMILY HEALTH INFORMATION				
ME	**HEALTH ISSUES**	**BLOOD RELATIVES**	**RELATIONSHIP TO YOU & details as needed** (example: Self, Son, M Aunt, P Cousin, PGM, MGF) M = Maternal (Mother's Side) P = Paternal (Father's Side)	
Yes No	Asthma	**Yes No**	Who	
Yes No	Cancer	**Yes No**	Who & Type Age at Diagnosis	
Yes No	Diabetes	**Yes No**	Who	
Yes No	Epilepsy	**Yes No**	Who	
Yes No	Heart Trouble	**Yes No**	Who & What	
Yes No	High Blood Pressure	**Yes No**	Who	
Yes No	Mental/Emotional Health Issues	**Yes No**	Who & Diagnosis	
Yes No	Stroke	**Yes No**	Who	
Yes No	Suicide Attempt	**Yes No**	Who	
Yes No	Thyroid Problems	**Yes No**	Who & Diagnosis	
Yes No	Tuberculosis	**Yes No**	Who	

Have you had any of the following tests?		**Date or Year & Where it was done**
Yes No	Cologuard	
Yes No	Fit Test	
Yes No	Colonoscopy	
Yes No	Flex Sigmoidoscopy	

Yes	**No**	Have you had any recent stressful LIFE CHANGES?
Yes	**No**	Do you feel unsafe in your current relationship?
Yes	**No**	I would like to talk privately (though others came with me)

«PName»	DOB: «PDOB»

Diseases	If yes, when?	Date last tested:
Chlamydia	**Yes No**	
HPV	**Yes No**	
Other Diseases	**Yes No**	
Yes No	Have you ever had a BLOOD TRANSFUSION?	
If yes, when?		
Yes No	Have you ever had a DEXA SCAN?	
If yes, when?		

WOMEN'S HEALTH	Date & Where Done
LMP (Date last period started)	
Date of LAST PAP SMEAR	
Date of LAST MAMMOGRAM	

Do you wear glasses?	Yes No	**Do you wear contacts?**	Yes No
Do you have hearing aids?	Yes No	**Right, Left, or Both**	
Do you have dentures?	Yes No	**Partial Dentures**	Upper Lower

PREGNANCIES Number ▼		G P	
Total Pregnancies		**Add'l Information/Loss**	
Full Term Birth		Died after birth	
Premature Birth			
Stillbirth			
Miscarriage			
Elective Abortion			

OTHER MEDICAL CARE:

Date/Year		Name Of Provider	Name & Location Of Clinic
	PRIOR PROVIDER		
	◂ Last Physical		
	EYE DOCTOR		
	◂ Last Dilated Eye Exam		
	DENTIST		
	◂ Last Dental Exam		
	SPECIALIST		
	Condition:		
	SPECIALIST		
	Condition:		

SURGERIES I HAVE HAD:

YEAR (approximate)	SURGERIES (examples) None, gallbladder, appendix, tooth removed, brain tumor, C-Section

HOSPITALIZATIONS:

YEAR (approximate)	I WAS IN THE HOSPITAL FOR: (If none, write "None")

INJURIES :

YEAR (approximate)	TYPE OF INJURY (If none, write "None") (Examples) Accidents, Broken Bones, Rape, Self-Inflicted Injury