Keokuk County Medical Clinic

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1314 South Stuart Street, Suite B | Sigourney, Iowa 52591
www.keokukhealth.com

Patient Medical History

Please answer all areas. When appropriate, please explain yes answers.

Section 1: Newborn Only | Past Medical History

Birth History ☐ Vaginal ☐ C-Section ☐ Full Term ☐ Pre-Term *(born less than 36 weeks)*

Patient's Birth Weight _____ Patient's Birth Length _____

Complications during or after Pregnancy ☐ No ☐ Yes _____

Problems with baby at birth: Breathing ☐ No ☐ Yes _____

Jaundice ☐ No ☐ Yes _____

Smoking during pregnancy ☐ No ☐ Yes _____

Alcohol during pregnancy ☐ No ☐ Yes _____

Illicit drug use during pregnancy ☐ No ☐ Yes _____

Hospitalizations ☐ No ☐ Yes _____

Surgeries ☐ No ☐ Yes _____

Chronic Illnesses ☐ No ☐ Yes _____

Recurrent ear infections ☐ No ☐ Yes _____

Lead Screen _____ Hearing Test _____

Section 2 | Patient's Medical History

Normal Pap Smear ☐ No ☐ Yes _____

ADHD ☐ No ☐ Yes _____

Anemia ☐ No ☐ Yes _____

Anxiety ☐ No ☐ Yes _____

Arthritis ☐ No ☐ Yes _____

Asthma ☐ No ☐ Yes _____

Back or Neck Problems ☐ No ☐ Yes _____

Cancer ☐ No ☐ Yes _____

Cardiac Arrhythmia ☐ No ☐ Yes _____

Chest Pain ☐ No ☐ Yes _____

Concussion ☐ No ☐ Yes _____

Congestive Heart Failure ☐ No ☐ Yes _____

COPD ☐ No ☐ Yes _____

Coronary Artery Disease ☐ No ☐ Yes _____

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Depression ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____

Fractures/Broken Bones ☐ No ☐ Yes _____

Heart Attack ☐ No ☐ Yes _____

High Blood Pressure ☐ No ☐ Yes _____

High Cholesterol ☐ No ☐ Yes _____

Migraines ☐ No ☐ Yes _____

Mental Illness ☐ No ☐ Yes _____

Osteoporosis ☐ No ☐ Yes _____

Pneumonia ☐ No ☐ Yes _____

Rhinitis ☐ No ☐ Yes _____

Seizures ☐ No ☐ Yes _____

Skin Problems ☐ No ☐ Yes _____

Stroke ☐ No ☐ Yes _____

Sleep Apnea ☐ No ☐ Yes _____

Stomach Issues ☐ No ☐ Yes _____

Hospitalizations ☐ No ☐ Yes _____

Section 3 | Surgical History

Appendectomy ☐ No ☐ Yes _____

Breast Biopsy ☐ No ☐ Yes _____

Cholecystectomy (Gallbladder) ☐ No ☐ Yes _____

Coronary Artery Bypass ☐ No ☐ Yes _____

Endoscopy/Colonoscopy ☐ No ☐ Yes _____

Hernia ☐ No ☐ Yes _____

Hip Replacement ☐ No ☐ Yes _____

Hysterectomy ☐ No ☐ Yes _____

Knee Replacement ☐ No ☐ Yes _____

Mammogram ☐ No ☐ Yes _____

Other surgical procedures ☐ No ☐ Yes _____

Section 4 | Social History

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation _____

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Never smoked ☐ Exposed to second hand smoke ☐ Chew tobacco

Highest level of education ☐ College ☐ High School ☐ G.E.D. ☐ Other

Number of people living in home _____ Pets in home _____

Alcohol Use ☐ No ☐ Yes (If yes, how much) _____

Illicit Drug Use ☐ No ☐ Yes (If yes, how much) _____

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Section 5 | Family History

Anxiety ☐ No ☐ Yes _____

Asthma ☐ No ☐ Yes _____

Cancer ☐ No ☐ Yes _____

Depression ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____

Heart Disease ☐ No ☐ Yes _____

Mental Illness ☐ No ☐ Yes _____

Stroke ☐ No ☐ Yes _____

Other ☐ No ☐ Yes _____

Is father deceased? ☐ No ☐ Yes Is mother deceased? ☐ No ☐ Yes

Section 6 | Allergies

List all allergies to medications _____

List all environmental allergies _____

Section 7 | Medications

List all over the counter and prescription medications with dosages and frequency.

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Completed by _____ Relationship to Patient _____

Signature _____ Date: _____ /_____ /_____