Yale
NewHaven
Health

Medical History

PATIENT INFORMATION

PATIENT NAME

BIRTH DATE

PREFERRED LANGUAGE

LEGAL SEX

GENDER IDENTITY

HOME STREET ADDRESS

TELEPHONE NUMBER

( )

TOWN/CITY

STATE

ZIP CODE

EMERGENCY CONTACT

NAME

TELEPHONE NUMBER

( )

MEDICAL INFORMATION

CHIEF COMPLAINT TODAY?

HAVE YOU BEEN TESTED FOR COVID-19? ☐ YES ☐ NO IF YES, WHAT WAS THE RESULT? ☐ POSITIVE ☐ NEGATIVE ☐ PENDING

DO YOU CURRENTLY OR HAVE YOU EVER USED TOBACCO OR VAPING PRODUCTS? ☐ YES ☐ NO

ALLERGIES

MEDICATION NAMES AND DOSAGE

PERTINENT RECENT MEDICAL/SURGICAL HISTORY

FAMILY MEDICAL HISTORY

PRIMARY MEDICAL PROVIDER AND PHONE NUMBER

Do you or have you had any of the following?

	Yes	No
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Blood Transfusion	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Chest Pains	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions	☐	☐
Diabetes	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
Excessive Thirst	☐	☐
Fainting Spells/Dizziness	☐	☐
Frequent Cough	☐	☐
Frequent Diarrhea	☐	☐
Frequent Headaches	☐	☐
Genital Herpes	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack/Failure	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Trouble/Disease	☐	☐
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Hives or Rash	☐	☐
Hypoglycemia	☐	☐

	Yes	No
Irregular Heartbeat	☐	☐
Kidney Problems	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mitrial Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Pain in Jaw Joints	☐	☐
Parathyroid Disease	☐	☐
Psychiatric Care	☐	☐
Radiation Treatments	☐	☐
Recent Weight Loss	☐	☐
Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐
Rheumatism	☐	☐
Scarlet Fever	☐	☐
Shingles	☐	☐
Sickle Cell Disease	☐	☐
Sinus Trouble	☐	☐
Spina Bifida	☐	☐
Stomach/Intestinal Disease	☐	☐
Stroke	☐	☐
Swelling of Limbs	☐	☐
Thyroid Disease	☐	☐
Tonsillitis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Women, are you:

	Yes	No
Pregnant/Trying to get pregnant	☐	☐
If yes, estimated due date: _____		
Taking oral contraceptives?	☐	☐
Breastfeeding	☐	☐

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE