Harmony Community Clinic

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Medical History Questionnaire

Your answers help us provide safe care. All information is confidential and part of your medical record.

Patient name (print) _____ Date of birth _____ Date _____

Height _____ Current weight _____ Goal weight (if applicable) _____ Last physical exam (approx.) _____

Main reason for your visit / health goals _____

Current medications

Include prescriptions, over-the-counter medicines, vitamins, supplements, herbal products, hormones, peptides, and weight-loss medicines.

Medication / supplement	Dose	How often	Reason

Allergies

- ☐ No known allergies
- ☐ Latex
- ☐ Lidocaine / numbing medicine
- ☐ Adhesive / tape
- ☐ Eggs
- ☐ Cow's milk protein

Medicine, food, or other substance	Reaction (rash, swelling, trouble breathing, etc.)

Medical conditions (check all that apply, past or present)

- ☐ High blood pressure
- ☐ Heart disease / heart attack
- ☐ Irregular heartbeat
- ☐ Heart failure
- ☐ Stroke / mini-stroke
- ☐ Blood clots (DVT / PE)
- ☐ High cholesterol
- ☐ Diabetes type 1
- ☐ Diabetes type 2 / prediabetes
- ☐ Thyroid disease
- ☐ Medullary thyroid cancer
- ☐ MEN2 syndrome
- ☐ Pancreatitis
- ☐ Gallbladder disease
- ☐ Liver disease
- ☐ Kidney disease / kidney stones
- ☐ Stomach / bowel disease
- ☐ Gastroparesis
- ☐ Asthma / COPD
- ☐ Sleep apnea
- ☐ Seizures
- ☐ Migraines
- ☐ Neuromuscular disease (e.g., myasthenia gravis)
- ☐ Autoimmune disease

- ☐ Bleeding or clotting disorder
- ☐ Cancer (type): _____
- ☐ Eating disorder (past or present)
- ☐ Cold sores (herpes)
- ☐ Prostate problems
- ☐ Anemia
- ☐ Depression / anxiety
- ☐ HIV / hepatitis
- ☐ Skin conditions
- ☐ Infertility
- ☐ G6PD deficiency
- ☐ Other mental health condition
- ☐ Keloids / abnormal scarring
- ☐ Glaucoma / eye disease
- ☐ Other: _____

Surgeries and hospitalizations

Surgery / reason for hospitalization	Year

Family history (parents, brothers, sisters, children)

- ☐ Heart disease
- ☐ Stroke
- ☐ Prostate cancer
- ☐ Other cancer: _____
- ☐ High blood pressure
- ☐ Blood clots
- ☐ Colon cancer
- ☐ Mental illness
- ☐ Diabetes
- ☐ Breast cancer
- ☐ Thyroid cancer / MEN2
- ☐ Other: _____

Lifestyle

	Yes	No
Do you currently smoke, vape, or use tobacco or nicotine?	☐	☐
Do you drink alcohol? If yes, about how many drinks per week? _____	☐	☐
Do you use recreational or non-prescribed drugs, including marijuana?	☐	☐
Do you exercise regularly? If yes, type and days per week: _____	☐	☐
Are you a competitive athlete, in the military, or subject to drug testing?	☐	☐

Women's health

First day of last menstrual period _____ Birth control method _____ Last mammogram _____ Last Pap test _____

	Yes	No
Are you pregnant or could you be pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Are you planning a pregnancy in the next 12 months?	☐	☐
Have you gone through menopause? If yes, at what age? _____	☐	☐

Men's health

Last PSA test (if known) _____ Result (if known) _____

	Yes	No
Are you trying to have children now or in the future?	☐	☐

	Yes	No
Do you have trouble urinating or a weak urine stream?	☐	☐

I confirm that the information on this questionnaire is accurate and complete to the best of my knowledge. I understand that leaving out information may affect the safety of my care, and I will update the clinic about any changes in my health or medications.

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.