Mashantucket Pequot Tribal Nation
Tribal Health Department
75 Route 2 PO Box 3260
Mashantucket, CT 06338-3260

Patient Name: ______________________
Date of Birth: ______________________
MRN: _________

Medical History Form

Allergies: ☐ NO ALLERGIES

Allergy	Reaction

Medications: *In addition to all prescriptions, please include over the counter medications and vitamins/supplements.*

Medication	Dose/Times Per Day	Medication	Dose/Times Per Day

If you need more room to list medications, please write them on a blank piece of paper with the required information or provide staff with a completed list to photocopy.

Health Maintenance Screening Test History:

Cholesterol	Date:	Facility/Provider:	Abnormal Result? Y / N
Colonoscopy	Date:	Facility/Provider:	Abnormal Result? Y / N
Mammogram	Date:	Facility/Provider:	Abnormal Result? Y / N
Pap Smear	Date:	Facility/Provider:	Abnormal Result? Y / N
Bone Density	Date:	Facility/Provider:	Abnormal Result? Y / N

Vaccination History:

Last Tetanus Booster/TdaP:	Last Pneumovax:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine:	

Women's Health History

Date of Last Menstrual Cycle:	Method of Contraception:
Total Number of Pregnancies:	Live Births:

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Personal Medical History:

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____________)			
COPD			
Depression/Anxiety			
Diabetes (Type 1 or Type 2)			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Renal (Kidney) Disease			
Migraine			
Thyroid Disease			
Other:			
Other:			
Other:			

Surgeries:

Type (specify left/right)	Date	Location/Facility

Other Providers/Specialists:

Specialist	Name	Last Visit
Cardiology		
Gastroenterologist		
OB/GYN		
Pulmonology		
Nephrology (Kidney)		
Other: ________________		
Other: ________________		

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Family Medical History:

Check all that apply	Mother	Father	Brother	Sister	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other: ____	Other: ____
Alcohol/Drug Abuse												
Asthma												
Cancer (Type: ____________)												
COPD												
Depression/Anxiety												
Bipolar												
Diabetes (Specify type 1 or 2)												
Early Death												
Heart Disease												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Stroke												
Thyroid Disease												
Other: ______________												
Other: ______________												

Notes:
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Additional Health Screening (GPRA)

Tobacco/Smoking		Yes	No
Do you currently smoke tobacco? (cigarettes. cigars, pipe, etc.)			
Have you smoked in the past?			
If yes:	**Current/Past use:** Packs/day______ # of years_____. **Quit date:** _______________		
	Do you want help quitting today?		
Do you use smokeless tobacco products (i.e. snuff, dip, etc.)			
Do you use tobacco products for cultural or religious purposes?			
Do you currently vape or use electronic cigarettes?			
Tobacco Exposure			
Are you exposed to tobacco at home? (i.e. family member smokes)			
Are your exposed to tobacco smoke outside the home? (i.e. work)			

Alcohol Screening	Yes	No
Have you ever felt that you need to cut down on your drinking?		
Have people annoyed you by criticizing your drinking?		
Have you ever felt guilty about drinking?		
Have you ever felt you need a drink first thing in the morning to steady your nerves or get rid of a hangover?		

Depression Screening
Over the **last 2 weeks**, how often have you been bothered by the following:

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing thing?	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
[COMPLETED BY STAFF] Total:				

Abuse Assessment		
Have you ever been emotionally or physically abused by your partner or someone important to you?	Yes	No
Are you afraid of your partner or someone else?	Yes	No
Have you ever felt bullied by anyone?	Yes	No