OKLAHOMA CITY INDIAN CLINIC

Initial Medical History Questionnaire (Long Form) - Adult

Date: Time:	Chart #
Patient Name:	DOB:

If this form is being completed by a parent or guardian, please print your name: _____Relationship to patient: _____

Sexual Orientation and Gender Identity:

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex (born with sexual anatomy, reproductive organs, and/or chromosome)

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male / Trans Man / Female-to-Male (FTM) ☐ Transgender Female / Trans Woman / Male-to-Female (MTF) ☐ Nonbinary / Genderqueer / Gender nonconforming ☐ Another identity: _____ ☐ Prefer not to disclose

Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other: _____

Allergies:

Allergy	Allergic Reaction

Female Reproductive History:

Last Menstrual Period	
Number of Pregnancies	
Number of Living Children	
Date and Location of Last Pap-smear	
Date and Location of Last Mammogram	
Current Birth Control	

Past History:

Cardiac	Respiratory	Digestive
☐ Chest Pain ☐High Blood Pressure ☐High Cholesterol ☐Heart Attack ☐Congestive Heart Failure ☐Heart Murmur ☐Other:	☐Cough ☐Asthma ☐COPD ☐COVID ☐Seasonal Allergies ☐Tuberculosis ☐Other	☐Gastroesophageal Reflux ☐Peptic Ulcer Disease ☐Hemorrhoids ☐Colitis ☐Gallstones ☐Celiac Disease ☐Other
Urinary	**Endocrine**	**Hematologic**
☐Prostate Enlargement ☐Kidney Stones ☐Urinary Infections ☐Kidney Failure ☐Urinary Incontinence ☐Prostatitis ☐Other	☐Diabetes ☐Thyroid Disease ☐Osteoporosis ☐Steroids ☐Adrenal Disorder ☐Pituitary Disorder ☐Other	☐Anemia ☐Bleeding Disorder ☐Blood Transfusions ☐Sickle Cell Anemia ☐Iron Deficiency ☐Blood Clots ☐Other
Neurologic	**Vision**	**Psychiatric**
☐Stroke ☐Seizures ☐Headache Disorders ☐Epilepsy ☐Alzheimer's Disease ☐Multiple Sclerosis ☐Other	☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Diabetic Retinopathy ☐Dry Eyes ☐Eye Infections ☐Other	☐Depression ☐Anxiety ☐Eating Disorder ☐Attention Deficit/Hyperactivity Disorder (ADHD) ☐Bipolar Disease ☐Autism Spectrum Disorder ☐Other:
Muscular	**Cancers**	**Other**
☐Back Pain ☐Arthritis ☐Muscular Dystrophies ☐Metabolic Disease ☐Spinal Muscular Atrophy ☐Amyotrophic Lateral Sclerosis (ALS) ☐Other	☐Breast Cancer ☐Prostate Cancer ☐Colon Cancer ☐Skin Cancer ☐Lymphoma ☐Ovarian Cancer ☐Other	

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Family Medical History:

Family Member	Living	Deceased	Age	Medical Problems
Mother				
Father				
Grandfather				
Grandmother				
Brother/Sister				
Brother/Sister				

Preventative Medical History:

Exam/Screening	Date	Facility
Last Dental Exam		
Last Tetanus Shot		
Last Flu Shot		
Last Pneumonia Shot		
Last Covid Shot		
Last Colonoscopy		
Last Bone Density		
Last Mammogram		

Surgeries:

What Kind	When (Year)	Facility

Medications: (Prescriptions, Vitamins, Over-the-Counter)

Drug	Dosage	Date Started

Patient/Guardian Full Name (Signature): _____ **Date:** _____ **Time:** _____

Initial Medical History Questionnaire Long Form- Adults Rev. 10-2025	Patient Label

SCAN FORM INTO EHR IN THE EVENT OF DOWNTIME