Hampstead Hospital
Quitting Time Medical History Form

Directions: Please provide the following information to the best of your knowledge.

Client Information				
Last Name:	**First Name**	**Middle Initial**	**Primary Language**	**Social Security #**
Street Address	**City**	**State**	**Zip**	**Sex:** ☐ **Male** ☐ **Female**
Home Phone	**Cell Phone**	**Work Phone**	**Preferred Method of Contact**	**Race/Ethnicity**
Date of Birth	**Marital Status** ☐ **Single without partner** ☐ **Single with partner** **Length of Time:** _____ ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**			
Emergency Contact Person:			**Phone Number**	**Relationship**

Primary Physician:	**Telephone:**
Date of Last Physical Exam:	☐ **Copy of physical exam within last year required**
Psychiatrist/Therapist Name:	**Telephone:**
Date of Last Visit:	

Medications

ALLERGIES:

Medication Name	Dosage	For what condition

Medical History

	***Chronic Productive Cough (over 3 weeks)**		***Shortness of Breath**		***Chest Pain**
	***Recurrent night sweats, chills, fever**		***Swollen Glands (neck, armpit, groin)**		***Persistent weight loss without dieting**
	***Tuberculosis**		***Dizziness/Confusion/ Wandering**		HIV
	Palpitations/arrhythmia		Heart Disease/Murmur		Hepatitis A, B or C
	High Cholesterol		Blood Clots/Thrombophlebitis		Frequent Headaches/Migraine
	Stroke		Seizure/Epilepsy		Weakness/Paralysis/Unsteady Walking
	High Blood Pressure/Low Blood Pressure		Forgetfulness/ Memory Loss		Cancer
	Arthritis		Anemia		Skin problems
	Diabetes		Asthma/ Pneumonia		Liver Problems
	Pancreatitis		Recurrent nausea/vomiting /diarrhea		Stomach/Bowel problems
	Gall Bladder Disease		Bladder/Kidney Problems		Hearing problems
	Depression/Psychiatric Disorder		Anxiety Disorder		Vision problems/Infections/Glaucoma
	Current Pain: ☐ Mild ☐ Moderate ☐ ***Severe**				

Nutritional Assessment

	Food Allergy:		Dietary Restrictions:		Poor intake for more than 5days past week
	Special Diet:		Chewing or Swallowing Problems		Unintentional weight loss or gain of 10 lbs or more within past month
	Nausea/Vomiting/Diarrhea in past 3 days		Active Eating Disorder		

Hospitalizations (list date & reason for hospitalization)

Medical/Surgical	
Psychiatric/Substance Abuse	

I certify that I have completed this information accurately and to the best of my knowledge.

Client Signature:_____Date: _____

☐ ***Areas checked with an asterisk * will immediately be reviewed by a RN for further assessment & recommendation***

QT Review Signature:	Date:	Time:
RN Review Signature:	Date:	Time: