Patient History

Patient Name _____ Date of Birth _____ Today's Date _____

Sex _____ Mobile _____ OK to leave message? Y N Previous PCP _____

What is the reason for your visit today? _____

_____

Medications you are currently taking:

Pharmacy Name _____ Address _____Phone _____

Medication	Dose (mg, units)	Frequency (daily, twice a day)

Medication Allergies _____

Preventative Care (please list date of last occurrence)

Annual Physical Exam _____ Eye Exam _____ Dental Exam _____ Colonoscopy _____

Vaccines (please list date of last dose

Influenza _____ Pneumonia (prevnar/pneumovax) _____ Tetanus _____ Shingles _____

Hepatitis B _____ Gardasil HPV _____ COVID-19 _____, _____, _____, _____

Female only:

Do you see an OB/GYN? Y N Which one? _____ Date of last menstrual period _____

Last PAP smear _____ Last mammogram _____ Last DEXA/Bone Density _____

What do you use for birth control? ☐ Birth control pills ☐ Condoms ☐ IUD ☐ Vasectomy ☐ None ☐ Other _____

Male only:

Do you see a urologist? _____ When was your last PSA check? _____

Do you have problems with erections? _____

Have you ever had an abdominal aorta aneurysm screening (Age >65 and history of smoking)? _____

Social History

Have you ever used tobacco products? Yes No

What kind? _____ Amount per day? _____

For how many years? _____ Quit date_____

Illicit drug use? Yes No What drug(s) _____

Do you drink alcohol? Yes No

How many drinks per week? _____

Have you ever felt you need to cut down? Yes No

How often do you exercise? _____

Sexually active with (check all that apply): ☐ one partner ☐ multiple partners ☐ women ☐ men ☐ both ☐ none

Marital Status: S M W D Do you have children? How many? _____

Occupation: _____ Place of employment: _____

SIGNATURE _____ **DATE** _____

Patient Name _____ Date of Birth _____ Today's Date _____

Past Medical History

Please check any of the following you have been diagnosed with: ☐ None

- ☐ ADHD/ADD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ B12 Deficiency
- ☐ Blood clot/DVT/PE
- ☐ Cancer, type _____
- ☐ COPD
- ☐ Diabetes
- ☐ Hearing Problem
- ☐ GERD/GI Issues
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease _____
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Hyper/Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Disorder
- ☐ Sleep Disorder (OSA)
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Urinary Problems
- ☐ Vit D Deficiency

☐ Injuries _____

☐ Hospitalizations _____

☐ Other _____

Past Surgical History

Please check all surgeries that you have had and include the date: ☐ None

- ☐ Appendectomy _____
- ☐ Back/Neck _____
- ☐ Breast _____
- ☐ CABG (bypass) _____
- ☐ C-section _____
- ☐ ENT _____
- ☐ Eye _____
- ☐ Gallbladder _____
- ☐ Gastric bypass _____
- ☐ Hernia _____
- ☐ Hysterectomy _____
- ☐ Joint Replacement _____
- ☐ Laparoscopy _____
- ☐ LEEP _____
- ☐ Mastectomy _____
- ☐ Pacemaker _____
- ☐ Prostate _____
- ☐ Stent/Heart Cath _____
- ☐ Thyroid _____
- ☐ Tonsillectomy _____
- ☐ Colon _____
- ☐ Bladder _____
- ☐ Tubal Ligation _____
- ☐ Ovarian _____
- ☐ Other _____
- ☐ Vasectomy _____

☐ Orthopedic _____

Family History

Please check if any immediate family members have had the following. Which family member?

- ☐ Alcohol Abuse _____
- ☐ Anemia _____
- ☐ Anxiety/Depression _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial Fibrillation _____
- ☐ Autoimmune Disorder ___
- ☐ Blood clot/DVT/PE _____
- ☐ Cancer, type _____
- ☐ COPD _____
- ☐ Dementia _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Headaches _____
- ☐ Heart Disease (MI) _____
- ☐ Liver Disease _____
- ☐ High Cholesterol _____
- ☐ Hypertension _____
- ☐ Hyper/Hypothyroidism__
- ☐ Irritable Bowel _____
- ☐ Kidney Disease _____
- ☐ Migraines _____
- ☐ Mitral Valve Prolapse ___
- ☐ Osteoporosis _____
- ☐ Peptic Ulcer Disease ____
- ☐ Peripheral Vascular Disease _____
- ☐ Seizures _____
- ☐ Sleep Disorder (OSA) ___
- ☐ Stroke _____
- ☐ Thyroid Disorder _____

☐ Other _____

SIGNATURE _____ **DATE** _____