

Patient Health Information

Date _____

Patient name: _____

DOB: _____

Patient's Care Team

Do you see any other health care providers (i.e. cardiologist, gynecologist, dermatologist)? If so please list their name, specialty, and phone number: _____

Pharmacy

Please list your pharmacy and phone number: _____

Allergies

Drug Allergies: Are you aware of any drug (medication) allergies? (*circle one*)

YES

NO

If yes, please list all drug allergies: _____

Environment/Inhaled/Food Allergies: Please list all other allergies _____

Current Medications

Please list all prescribed medications, over the counter medications, supplements, and vitamins with appropriate dosages that you are currently taking: _____

Vaccinations

Please list any adult immunizations and dates: _____

Past Medical History

Please check all conditions and problem areas that apply to you.

- | | | | |
|-----------------------------|-----------------------------|---------------------------|----------------------|
| ___ ADHD | ___ Coronary artery disease | ___ Heart murmur | ___ Osteoporosis |
| ___ Allergies | ___ DVT/blood clot | ___ Hemorrhoids | ___ Psych disorder |
| ___ Anemia | ___ Dementia | ___ High blood pressure | ___ Seizures |
| ___ Anxiety | ___ Depression | ___ High cholesterol | ___ Skin problems |
| ___ Arthritis/Joint Disease | ___ Diabetes | ___ Kidney disease | ___ Sleep disorders |
| ___ Asthma | ___ GERD (acid reflux) | ___ Kidney stones | ___ Stomach issues |
| ___ Bladder/kidney problems | ___ HIV | ___ Liver disease | ___ Thyroid problems |
| ___ Bleeding disorder | ___ Headaches | ___ Memory loss | ___ Vision problems |
| ___ COPD/lung disease | ___ Hearing problems | ___ Mood disorders | ___ Weight problems |
| ___ CVA/stroke | ___ Heart disease | ___ Muscle/joint problems | Other: _____ |

Surgical History

Please list all previous surgeries and dates: _____

Family History

Please list any medical conditions your family members have:

- Mother:** Alive, at age: _____ Health problems: _____
Died, at age: _____ Cause of death: _____
- Father:** Alive, at age: _____ Health problems: _____
Died, at age: _____ Cause of death: _____
- Maternal Grandmother:** Alive, at age: _____ Health problems: _____
Died, at age: _____ Cause of death: _____
- Maternal Grandfather:** Alive, at age: _____ Health problems: _____
Died, at age: _____ Cause of death: _____
- Paternal Grandmother:** Alive, at age: _____ Health problems: _____
Died, at age: _____ Cause of death: _____

Family History (continued)

Paternal Grandfather: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Siblings: # of brothers: _____ Health problems: _____

of sisters: _____ Health problems: _____

Social History

Smoking status: (*circle one*) Never smoker Former smoker Current every day smoker Current some day smoker

Smoking – how much? (*circle one*) (*note: PPW = pack per week, PPD = pack per day*)

None 1 PPW 2 PPW ¼ PPD ½ PPD 1 PPD 1 ½ PPD 2 PPD 3+ PPD

How many years have you smoked? _____ **When did you quit smoking?** _____

Occupation: _____

Education: (*circle one*) Less than 8th grade 2 year college 4 year college Post graduate

Sexual orientation: (*circle one*) Heterosexual Homosexual Bisexual

Marital status: (*circle one*) Married Single Divorced Domestic partner Widowed

Number of children: _____

Exercise level: (*circle one*) None Occasional Moderate Heavy

Diet: (*circle one*) Regular Vegetarian Vegan Gluten Free

General stress level: (*circle one*) Low Medium High

Passive smoke exposure: (*circle one*) Yes No

Chewing tobacco: (*circle one*) None 1/day 2-4/day 5+/day

Alcohol intake: (*circle one*) None Occasional Moderate Heavy

Alcohol years of use: _____

Drug use: _____

Caffeine intake: (*circle one*) None Occasional Moderate Heavy

Smoke alarm in home: (*circle one*) Yes No **Advance directive:** (*circle one*) Yes No

Sexually active: (*circle one*) Yes No **Protected sex:** (*circle one*) Always Usually No

Recent colonoscopy? (*Please list date of procedure*): _____

GYN History (For female patients only)

Date of last menstrual period: _____ **Menses monthly?:** (*circle one*) Yes No

Frequency of cycle (every ___ days): _____ **Duration of flow:** _____

Flow: (*circle one*) Light Moderate Heavy

Age when you first got your period? _____ **If postmenopausal, age at menopause?** _____

Current birth control method: _____ **Age at first child:** _____

Date of last mammogram: _____ **Date of last pap smear:** _____

Sexually active: (*circle one*) Yes No **History of STD's:** (*circle one*) Yes No

Did you get the HPV vaccine? (*circle one*) Yes No

Date of most recent bone density test: _____

Are you on hormone replacement therapy? (*circle one*) Yes No