

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.

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