Patient History Form

Name: _____ Date of Birth: _____ Age: _____ Date: _____

**** Any section that you have already filled out during your pre-visit or self-check-in may be skipped****

Preferred Local Pharmacy: _____ Preferred Mail Order Pharmacy: _____

Preferred Imaging Center: _____ Preferred Lab Center: _____

Chief Complaint (current symptoms)

1. _____
2. _____
3. _____

Immunizations and Wellness

	Date		Date		Date
Last Tetanus Shot		Last Flu Shot		Last Pneumonia Shot	
Shingles Shot		COVID Shot(s) (Moderna, Pfizer, JJ)		Last Dilated Eye Exam	
Last Colonoscopy		Last Bone Density Test		Last Cholesterol Test	
Female: Last Mammogram		**Female:** Last Pap Smear Have you ever had an abnormal Pap (Yes/No) If yes, date.		**Male:** Last PSA	

Past Medical History: Please check if you have ever had:

	Yes		Yes		Yes
Alcoholism		Depression		Respiratory Disease (i.e., COPD)	
Allergies (Seasonal, Environmental)		Diabetes		Seizure Disorder	
Anemia		Heart Arrhythmia/Palpitations		Sexually Transmitted Infection	
Anxiety Disorder		Heart Attack or Bypass Surgery		Steroid Use	
Arthritis		Heart Disease		Stomach Ulcer	
Asthma		High Blood Pressure		Stroke	
Birth Defects		High Cholesterol		Thyroid Disorder	
Blood Clots		Kidney Disease		Tobacco Use	
Blood Transfusion		Liver Disease		Other: _____	
Bone Fracture		Osteoporosis		Other: _____	
Cancer (type) _____		Reflux		Other: _____	

Surgeries: Please list any surgeries you have had below and the approximate dates (Month and year):

1.	Date:	4.	Date:
2.	Date:	5.	Date:
3.	Date:	6.	Date:

Family History: Please indicate the relationship of the family member who has had any of the following (i.e., paternal aunt)

	Who		Who		Who
Blood Clots		Diabetes		Ovarian Cancer	
Breast Cancer		Heart Disease		Prostate Cancer	
Colon Cancer		Osteoporosis		Stroke	
Depression		Hip Fracture		Other _____	
Father: Current age _____, If deceased, age at death ____			Sibling: Current age _____, If deceased, age at death ____		
Mother: Current age _____, If deceased, age at death ____			Sibling: Current age _____, If deceased, age at death ____		
			Sibling: Current age _____, If deceased, age at death ____		

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Social History:

Marital Status	□ Single □ Married □ Separated □ Divorced □ Widowed	Number of children _____
Tobacco Use	□ Never □ Current □ Previous	Year Began _____ Year Quit_____ # packs per day ____
Alcohol Use	□ Never □ Current □ Previous	Year Began _____ Year Quit _____ # drinks per week _____
Exercise	□ Low □ Moderate □ Vigorous	Type: _____ Frequency: _____
Caffeine	□ Never □ Yes	Type: _____ Amount per day: _____
Occupation		

Recent travel: □ None □ Out of state □ Out of country Location: _____

Do you have an advance directive or living will? □ Yes □ No Does this office have a copy? □ Yes □ No
Are you interested in talking about your wishes for when or if you are unable to make medical decisions on your own? □ Yes □ No

Allergies:
Please list any allergies to medication or foods. Example of reaction: rash or hives, trouble breathing, nausea.

Name	Reaction	Name	Reaction
1.		4.	
2.		5.	
3.		6.	

Medication:
Include prescription and over-the-counter medication. Feel free to attach a list of medication.

Name	Dose	Frequency

What specialists do you currently see?

Provider Name	Specialty	Phone number