NAME ______________________________ DATE OF BIRTH______________________

MEDICATIONS

Medication Name (include all prescriptions, vitamins & over the counter)	Dose	Frequency	For what?

ALLERGIES/CONTRAINDICTIONS

○ No known allergies

Name	Reaction

MEDICAL HISTORY

Allergies	YES	NO		Depression	YES	NO		Myocardial Infarction	YES	NO
Anemia	YES	NO		Diabetes Mellitus	YES	NO		Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO		Dexa/Bone Density	YES	NO		Osteoporosis	YES	NO
Arthritis	YES	NO		Emphysema	YES	NO		Seizures	YES	NO
Asthma	YES	NO		GERD	YES	NO		Shortness of Breath	YES	NO
Blood Transfusion	YES	NO		Glaucoma	YES	NO		Sickle Cell Anemia	YES	NO
Cancer	YES	NO		Heart Murmur	YES	NO		Stroke	YES	NO
Cataracts	YES	NO		High Cholesterol	YES	NO		Substance Abuse	YES	NO
Chest Pain	YES	NO		HIV/ AIDS	YES	NO		Thyroid Disease	YES	NO
CHF	YES	NO		Hypertension	YES	NO		Tuberculosis	YES	NO
Clotting Disorder	YES	NO		Kidney Disease	YES	NO		Ulcers	YES	NO
COPD	YES	NO		Meningitis	YES	NO		Migraines	YES	NO
Fatigue	YES	NO		Sleep Apnea	YES	NO				

Other Medical History:
____

SURGICAL HISTORY

AAA Repair	YES	NO		Colon Surgery	YES	NO		Joint Replacement	YES	NO
Appendectomy	YES	NO		Cosmetic Surgery	YES	NO		Intestine Surgery	YES	NO
Brain Surgery	YES	NO		Eye Surgery	YES	NO		Spine Surgery	YES	NO
CABG	YES	NO		Fracture Surgery	YES	NO		Tonsillectomy	YES	NO
Cholecystectomy	YES	NO		Hernia Repair	YES	NO		Tubal ligation	YES	NO
Colon/ Bowel Surgery	YES	NO		Hysterectomy	YES	NO		Valve Replacement	YES	NO
				Vasectomy	YES	NO		Prostate Surgery	YES	NO

Other Surgical History: ____

NAME ____ DATE OF BIRTH_____________________

FAMILY HISTORY

Relationship	Alive?		Alcohol Abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments
Mother	Y N																			
Father	Y N																			
Sister 1	Y N																			
Sister 2	Y N																			
Sister 3	Y N																			
Brother 1	Y N																			
Brother 2	Y N																			
Brother 3	Y N																			
Son 1	Y N																			
Son 2	Y N																			
Daughter 1	Y N																			
Daughter 2	Y N																			
Mat GM	Y N																			
Mat GF	Y N																			
Pat GM	Y N																			
Pat GF	Y N																			
	Y N																			
	Y N																			
	Y N																			

○ Adopted ○ Family History Unknown

Other Family History: ____

____

____

ALCOHOL SCREEN

Have you ever had more than 4 drinks in a day? Yes No

How many times in the past 12 months? ⓪①②③④⑤+

SOCIAL HISTORY

Alcohol Use? Yes No

Drinks/Week

	Glasses of wine
	Cans of beer
	Shots of liquor
	Drinks containing 0.5oz of alcohol

Sexually Active? Yes No Not Currently

Partners Female Male

Birth Control/Protection:

None

Abstinence	Coitus Interruptus	Condom	Diaphragm
Implant	Injection	Inserts	IUD
OCP	Patch	Post-menopausal	Rhythm
Spermicide	Sponge	Surgical	Other-see comments

NAME ____ DATE OF BIRTH______________________

Drug Use? Yes No
Use/week ________ times a week
Type

Amphetamines	Amyl Nitrate	Anabolic Steroids	Barbiturates
Benzodiazepines	"Crack" cocaine	Cocaine	Codeine
Fentanyl	Other	GHB	Hashish
Heroin	Hydrocodone	Hydromorphone	Ketamine
LSD	Marijuana	MDMA (Ecstasy)	Mescaline
Methamphetamines	Methaqualone	Methylphenidate	Morphine
Nitrous Oxide	Opium	Oxycodone	PCP
Psilocybin	Solvent Inhalants	Other- see comments	

Comments:
____

Tobacco Use? Yes No

If so, Ready to Quit? Yes No

○ Smoker, Currently # Packs/day: _______________
○ Former Smoker, Previously Quit Date: _______________ # Packs/day: _______________

○ Smokeless Tobacco, Currently
○ Smokeless Tobacco, Previously Quit Date: ___________ # Packs/day: _______________

Comments: ____

SOCIOECONOMIC HISTORY

Occupation: ____ ○ Retired

Employer: ____

Spouse Name	
# of Children	
Language	English Spanish Chinese French Vietnamese Arabic German Greek Italian Hindi Russian Sign Language Thai Somali Other:___________________
Ethnicity	Hispanic or Latino Non-Hispanic or Latino
Race	Black/African American White/Caucasian Asian American Indian Hawaiian/Pacific Islander Other Refuse to answer

Lives with: ____

HEALTH MAINTENANCE

Please document the date of last completion and results if appropriate for the following:

Screening	Date Completed	Result/Comments
Pap smear / pelvic (women only)		Normal or Abnormal?
Mammogram		Normal or Abnormal?
Colonoscopy		Normal or Abnormal?
DEXA./Bone Density Scan		Normal or Abnormal?
PSA (men only)		Normal or Abnormal?

NAME ____ DATE OF BIRTH______________________

VACCINATIONS

	Have you received this vaccine?	Year(s) given
Influenza vaccine	Yes No Don't Know	
Hepatitis vaccine	Yes No Don't Know	
Pneumonia Vaccine (Pneumovax or Prevnar13)	Yes No Don't Know	
Tetanus	Yes No Don't Know	
TdaP	Yes No Don't Know	
Zoster/shingles vaccine	Yes No Don't Know	
HPV vaccine	Yes No Don't Know	
BCG (outside U.S.)	Yes No Don't Know	

OTHER PHYSICIANS

As your Primary Care Provider, it is our job to make sure we keep current with your other physicians and careteams. Please list your providers names below.

Heart specialist:	OB/GYN:
Digestive specialist:	Neurologist:
Endocrinologist:	Eye Doctor:
Orthopedist:	Pain Management:
Urologist:	Physical/Occ therapist:
Kidney specialist:	Dermatologist:
Counseler:	Cancer specialist:
Other:	

Are you interested in signing up for our Patient Portal, MyChart? Yes No