Name: _____

DOB: _____

General Medical Information & Health History

Reason for today's visit: _____

Where were you getting your care before? _____

Do you currently see any specialists? _____

MEDICATIONS: Please list (or provide a list) all prescriptions and non-prescription medications that you take. □ TAKE NO MEDICATIONS OR SUPPLEMENTS

	Medication Name	Dose	How many times per day?
1.			
2.			
3.			
4.			
5.			

Allergies or intolerance to medications (include type of reaction):

_____ □ NONE

HEALTH MAINTENANCE SCREENING TESTS

Test	Date	Normal?
Cholesterol		
Colonoscopy		
CT Lung Screen		
PSA		
Mammogram		
Pap Smear		
Bone Density		

IMMUNIZATIONS

Vaccine	Date	Date
Influenza (Flu)		
Shingles		
Pneumonia		
Tetanus		
Covid-19		

Smoke cigarettes: □ Never

□ No-Previous Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

□ Yes- Current Smoker Packs/day: _____ # of years: _____

Other tobacco: □ Pipe □Cigar □Snuff □Chew

Do you drink alcohol? □No □Yes If yes, number of drinks/week:_____ □Beer □Wine □Liquor

Do you use recreational drugs? □No □Yes If yes, how often? _____

Do you drink caffeine regularly? □ No □ Yes If yes, how much/often: _____

SURGICAL HISTORY: Please list any previous surgeries and/or hospitalizations:

Type of Surgery/Hospitalization Date What Facility/Hospital?

_____

_____

_____

PERSONAL & FAMILY HISTORY

Disease	Self	Father	Mother	Brother	Sister
Alcoholism/Drug Abuse					
Alzheimer's/Dementia					
Asthma					
Cancer					
Depression/Suicide/Anxiety					
Diabetes					
Eczema/Psoriasis					
Heart Attack/Stroke					
Heart Disease/Heart Failure					
High Blood Pressure					
High Cholesterol					
Migraines					
Thyroid Disease					
Other (Please List)					

PAST MEDICAL HISTORY: _____

_____

_____

Please list any other medical conditions you may have had or are experiencing:

_____

_____

Patient Signature: _____ **Date:** _____