Name: ______________________________
DOB: ______________________________

PATIENT HISTORY

Preventive Health

Immunization	Date Performed	Screening Test	Date Performed
COVID-19		Colonoscopy/Cologuard	
Influenza Vaccination		Mammogram	
Prevnar (1st Pneumonia shot)		PAP	
Pneumovax(2nd Pneumonia		PSA (Prostate)	
Tetanus Vaccination		DEXA/ bone density	
TDAP (Whooping cough)		Breast ultrasound	
Zostavax (Shingles vaccine)			
Shingrix (Shingles vaccine)			

Medications

Please list all medications you are taking currently, including over the counter and herbal remedies.

Medication Name:	**Dosage (mg, cc, etc)**	**Frequency (how often)**

Past Medical History

Please mark any current or previous illnesses or health problems.

- ☐ ADD/ ADHD
- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ Blood Clots
- ☐ Cancer (type)____________________
- ☐ COPD
- ☐ Chronic Pain related to ___________ ______________________________
- ☐ Depression
- ☐ Degenerative Joint Disease
- ☐ Diabetes Mellitus
- ☐ Drug/ Alcohol Addiction
- ☐ Female Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lung Problems
- ☐ Male Problems
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Thyroid Diesease

Allergies

Please list all food and drug allergies:

____ ____
____ ____
____ ____
____ ____

Name: ______________________________
DOB: ______________________________

Surgical History / Major Diagnostic Procedures

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric Surgery
- ☐ Breast
  (was surgery involved _______)
- ☐ C-Section
- ☐ Gall Bladder
- ☐ Lung Biopsy
- ☐ Heart Catheterization
- ☐ Heart Bypass Surgery
- ☐ Prostate Surgery
- ☐ Other: ____
- ☐ Hysterectomy
  (was cancer involved____)
- ☐ Tonsillectomy
- ☐ Tumor Removal
- ☐ Vasectomy

Hospitalizations/Emergency Room Visits

Reason:	**Date:**

Social History

Have you ever smoked? (cigarettes, vape, cigars, etc.) ☐ No ☐ Yes

How many per day? _______________ How many years? Stop date: ____________

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week? _________________

Do you use any street drugs? ☐ No ☐ Yes If yes, please list _________________________

Family History

Are you adopted? Yes _____ No ______

	Father	Mother	Siblings	Children
Living				
Deceased				
Diabetes				
Hypertension				
Heart Disease				
Mental Illness				
Cancer (type)				
Stroke				
Thyroid Disease				
High Cholesterol				
Blood Clots				
Lung Disease				
Tuberculosis				
Mental Illness				
Headaches				
Seizure				
COPD/Emphysema				
Other (specify)				
Unknown				