

**Medical History**

Have **YOU** had any of the following illnesses: (circle)

Heart - Heart attack, Stroke, HBP, High Cholesterol, Heart Murmur

Lungs - Asthma, Pneumonia, COPD, TB, Sleep Apnea

GI - PUD, Colitis, IBS, Hepatitis, GERD, Cirrhosis

GU - Renal Failure, UTIs, Menstrual disorder, ED, STDs

MUSK - Back Pain, Osteoporosis, Herniated Disc, Arthritis

Psych - Anxiety, Depression, Panic Disorder, Suicidal, Homicidal, ADHD, Bi-Polar, Schizophrenic

Neuro - Epilepsy, Headaches, Seizures, Neuropathy, Meningitis

Endocrinology - Diabetes, Hypothyroidism, Hyperthyroidism, PCOS, Parkinson's

Skin - Eczema, Acne, Psoriasis, Rosacea

Misc - Measles, Mumps, Chicken pox, Mononucleosis, Scarlet fever, Glaucoma, Hearing trouble

Cancer (type) \_\_\_\_\_

Any others not listed \_\_\_\_\_

Colonoscopy (Adults age 50-75) within last 9 years or Sigmoidoscopy within the last four years

Date: \_\_\_\_\_ Provider \_\_\_\_\_ Results: Normal or Abnormal

Mammogram (F 50-74) within the last four years

Date: \_\_\_\_\_ Provider \_\_\_\_\_ Results: Normal or Abnormal

PAP smear (F 21-64) within the last three years

Date: \_\_\_\_\_ Provider \_\_\_\_\_ Results: Normal or Abnormal

**Surgery History:** List any **hospital admissions** (including surgeries) or medical conditions not listed above

Surgery/Procedure/Condition	Year	Provider	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Family History:** Have any **relatives** had any of the conditions listed above

Father \_\_\_\_\_ Mother \_\_\_\_\_

Sibling \_\_\_\_\_ Grandparent \_\_\_\_\_

Do you smoke? Yes or No packs per day \_\_\_\_\_ #of years \_\_\_\_\_

Do you drink alcohol? Yes or No How many drinks per day? \_\_\_\_\_ Drinks per week? \_\_\_\_\_

Do you use illicit drugs? Yes or No List: \_\_\_\_\_

Are you sexually active? Yes or No

**Immunizations** are up to date? Yes or No Release of immunization records needed? Yes or No

Dates: Tetanus \_\_\_\_\_ Flu \_\_\_\_\_ Shingles \_\_\_\_\_ Pneumonia \_\_\_\_\_

List your **Current Medications:** (Include over the counter medications, herbals and vitamins)

Medication	Dosage	Prescribing Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____

*All medications may contain side effects. You are strongly urged to bring our attention to any problem that you may be having with your medications.*

List all **Drug Allergies** and specific reactions

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

**Over the past 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all	Several Days	More than half the days	Nearly Every Day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed or hopeless	0	1	2	3
3) Feeling nervous, anxious, or on edge	0	1	2	3
4) Not being able to stop or control worrying	0	1	2	3

Do you have adequate food and housing? Yes or No - CCR given \_\_\_\_\_ staff initials

**Who is your Primary Care Provider?** Gary Ochs or Justin Green or Other: \_\_\_\_\_

What was the date of your last physical? \_\_\_\_\_

Do you have an advanced care plan? Yes or No.

Patient Name _____/_____/_____
Date of Birth ____/____/____

Signature (guardian or parent if minor under 18)

Date