Medical History

_____
Patient Name
_____/_____/_____
Date of Birth

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.

_____ _____
Signature (guardian or parent if minor under 18) **Date**