Date: _______________

PATIENT MEDICAL HISTORY FORM

Please complete this to the best of your ability. Use the space on the last page to include any additional information.

Name: ____________________ Date of Birth: _____________

Pronouns: ____________

Address (Street/City/State/Zip): ____

Home Phone: _________________ Work Phone: ________________ Cell Phone: _______________

Email Address: ______________________ Preferred Pharmacy (Name/Location): ________________________

Emergency Contact: _________________ Phone Number: _________________

<u>Past Medical History:</u>

What medical problems have you been diagnosed with in the past?

____

____

____

____

What surgeries have you had in the past?

____

____

What have you been hospitalized for in the past *(include the date and hospital name)*?

____

____

What medications are you currently taking?

____

____

____

What supplements, vitamins, or herbs do you take? How much of each do you take?

____

____

Do you have any allergies to medications? If so, what are these medications and what happened when you took them?

____

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Family History:

Name your father's medical problems: ______________________________

Name your mother's medical problems: ______________________________

What medical problems do your siblings have? ______________________________

What other medical problems run in your family? ______________________________

Social History:

1. Do you smoke cigarettes now? ☐ Yes ☐ No
   - If "No", did you smoke cigarettes in the past? ☐ Yes ☐ No
   - What age did you start smoking? _____ If you have quit, when did you do so? ______________
   - On average, how many packs of cigarettes do you, or did you smoke per day? ______________
2. Do you drink alcohol? ☐ Yes ☐ No What do you normally like do drink? ______________________
   - How many drinks do you have on average each week? ______________________________
   - Have you ever had a problem with alcohol (now or in the past)? ☐ Yes ☐ No
   - If yes, please provide more details: ______________________________
   - Do you drink because you like the taste of alcohol or for some other reason (i.e., it relaxes you, or that it helps you sleep)? ______________________________
3. Do you use marijuana? ☐ Yes ☐ No
   - How much, for how long, and how often? ______________________________
4. Do you take any other drugs that are not prescription? ☐ Yes ☐ No
   - What type of mediation (s) and how much? ______________________________
5. Do you exercise? ☐ Yes ☐ No What type of and how often? ______________________________
   - If you answered "No", what has stopped you from doing so?______________________________
     ____
6. Are you currently in a sexual relationship with someone? ☐ Yes ☐ No
   - How do you protect against getting pregnant? ______________________________
   - How do you protect against getting sexual transmitted infections? ______________________
7. Do you have any religious or spiritual beliefs that you believe could influence your care? If so, please explain: ______________________________

Adult Immunizations:

1. When was your last tetanus booster? ______________________________
2. Have you had the pneumonia shot? There are two recommended (Prevnar 13 & Pneumovax)?
   Check the appropriate boxes:
   ☐ I have not had either of them
   ☐ I have not had PCV13 ☐ I did have the PCV13: Date_________
   ☐ I have not had the Pneumovax ☐ I did have the Pneumovax: Date_________
   ☐ I am not sure
   Comments: ______________________________

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3. Have you had chicken pox in the past? ☐ Yes ☐ No
4. Have you had the Shingles vaccination (Zostavax or Shingrix)? ☐ Yes ☐ No When? ___________
5. Have you had the HPV, or Gardisil, vaccination? ☐ Yes ☐ No
   - If you are a female, have you had an abnormal pap smear in the past? ☐ Yes ☐ No
   - If you have an had an abnormal pap smear, what was done to treat the problem?
     ____
     ____

Any Addition Comments/Thoughts that you need your provider to know:

Patient Name: __________________________ **Date:** __________________

Patient Signature: _______________________