Family Centered
HEALTHCARE, P.A.

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: _____

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

Home phone: _____ Work phone: _____ Cell phone: _____

Email address: _____ Preferred Pharmacy (Name/Location): _____

Emergency contact: _____ Phone#: _____

Past Medical History:

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?

_____

Family History:

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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 to 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, give more details: _____
   - Do you drink because you like the taste of alcohol or for some other reason (like 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 types and how much? _____
5. Do you exercise? ☐ Yes ☐ No. What type and how often? _____
   - If you do not exercise. 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 sexually transmitted infections? _____
7. Do you have any religious or spiritual beliefs that you believe could influence your care? If so, what? _____

Adult Immunizations:

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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: _____
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 had an abnormal pap, what was done to treat the problem?
     _____
     _____

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

Patient Signature: _____ **Date:** _____