FAMILY MEDICINE CLINIC AND CAMPUS HEALTH CENTER

PATIENT HEALTH INFORMATION FORM

Name: ________________________ **DOB:** ________________________ **Today's Date:** _____________________

Reason for today's visit:

____

ALLERGIES & ADVERSE REACTIONS: (Including foods, latex, and all medications)

☐ **No Know Allergies or Adverse Reactions** (Move to the next section if you check NO)

☐ Contrast Dye	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________
☐ Food	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________
☐ Latex	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________
☐ Penicillin	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________
☐ Sulfa	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________
☐ Other: (Please List)	☐ Rash	☐ Trouble Breathing	☐ Other ______________________________

PRESCRIPTION MEDICATIONS:

	Name	Reason Taking	Dose	Route (mouth, etc.)	Frequency
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

OVER-THE-COUNTER MEDICATIONS: (Including vitamins, tonics, herbs, supplements, laxatives, etc.)

	Name	Reason Taking	Dose	Route (mouth, etc.)	Frequency
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Preferred Pharmacy: ____

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MEDICAL HISTORY: (Conditions diagnosed by a Physician/Provider)

Major Active Health Conditions: (Check all that apply)

☐ Arthritis	☐ Anxiety	☐ Asthma	☐ Back Pain	☐ Blood Clots	☐ Depression
☐ Diabetes	☐ Eye Disease	☐ Heart Disease	☐ Heartburn	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney	☐ Lung Disease	☐ Memory Issues	☐ Migraines	☐ Obesity	☐ Osteoporosis
☐ Seizures	☐ Sleep Apnea	☐ Stroke	☐ Thyroid	☐ **Cancer:** (type)______________________	

☐ Other: (please list) ____

SURGICAL HISTORY: (List all surgeries and dates)

Surgery	Yes	No	Date	Surgery	Yes	No	Date
Appendectomy	☐	☐	___________	Cesarean Section	☐	☐	_______________
Coronary Artery Bypass Graft	☐	☐	___________	Hysterectomy	☐	☐	_______________
Gall Bladder Removed	☐	☐	___________	Tonsils/Adenoids	☐	☐	_______________

List any other surgeries ____

FAMILY HISTORY:

(Complete the table below to show which blood relatives have/had the following health conditions)

	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Father	Mother	Brother	Sister
Breast Cancer								
Colon Cancer								
Prostate Cancer								
Other Cancers								
Heart Attack (Before 50)								
High Blood Pressure								
Diabetes								
Stroke (Before 50)								
Serious Alcohol Problems								
Mental Health Problems								
Blindness								
Other Hereditary Disease: (please list)								

WOMEN'S HEALTH:

Menstrual Period Date: ____________ **First Period Age:** _______________ **Menopause Age:** ___________
Number of Pregnancies: ____________ **Number of Live Births:** ____________
Date of Last Pap Smear: _____________________ **Results:** _______________
Date of Last Mammogram: ___________________ **Results:** _______________

ADVANCE DIRECTIVES:

Do you have an Advance Directive? (Such as a Living Will or a Medical Power of Attorney) ☐ **Yes** ☐ **No**
Blood Transfusion: Will you accept Blood? ☐ **Yes** ☐ **No**

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PERIODIC HEALTH MAINTENANCE:

CANCER SCREENING				IMMUNIZATIONS			
	Yes	No	Date		Yes	No	Date
PSA	☐ Yes	☐ No		**Influenza**	☐ Yes	☐ No	
Stool Cards	☐ Yes	☐ No		**Pneumovax**	☐ Yes	☐ No	
Scope Procedure	☐ Yes	☐ No		**Tetanus Shot**	☐ Yes	☐ No	
VISUAL SCREENING				**Hepatitis A**	☐ Yes	☐ No	
Eye Exam	☐ Yes	☐ No		**Hepatitis B**	☐ Yes	☐ No	
Other				RESPIRATORY			
TB Test	☐ Yes	☐ No		**Do you use oxygen?**	☐ Yes	☐ No	How much?
				Do you use CPAP?	☐ Yes	☐ No	

Birth Control						
☐ **None**	☐ **Birth Control Pills**	☐ **Condom**	☐ **Diaphragm**	☐ **Implant**	☐ **IUD**	☐ **Other**
☐ **Ring**	☐ **Post-Menopausal**	☐ **Patch**	☐ **Surgical Procedure (**Vasectomy/Tubal Ligation)			

Exercise			
Do you exercise?	☐ **Yes**	☐ **No**	**How Often?** (days/week)/ **How Long?** (minutes/day)

SOCIAL HISTORY:

Primary Occupation: ____

Work Status	☐ **Full Time**	☐ **Part-time**	☐ **Unemployed**	☐ **Sick Leave**	☐ **Disabled**	☐ **Retired**
Marital Status	☐ **Single**	☐ **Married**	☐ **Separated**	☐ **Divorced**	☐ **Widowed**	
Live with	☐ **Alone**	☐ **Spouse**	☐ **Significant Other**	☐ **Children**	☐ **Friend(s)**	☐ **Other:** __________
Live in	☐ **House**	☐ **Apt**	☐ **Assisted Living**	☐ **Retirement Housing**		☐ **Other:** __________

Caffeine Use: ☐ **Never** ☐ **Amount per day**___________________________

Tobacco Use (include cigarettes, pipes, cigars, chewing tobacco, etc.) ☐ **Never** ☐ **Current User** ☐ **Ex-User** When did you quit? _____________

Type_______________________ **Packs per Day:** _____________ **Years:** _____________

Alcohol Use: ☐ **Never** ☐ **Amount per day** _________________________

☐ **Have you ever felt the need to cut down on drinking?**	☐ **Yes**	☐ **No**
☐ **Have you felt annoyed by criticism of your drinking?**	☐ **Yes**	☐ **No**
☐ **Have you ever felt guilty about your drinking?**	☐ **Yes**	☐ **No**
☐ **Have you ever taken a morning eye opener**	☐ **Yes**	☐ **No**
Other Substance Use	☐ **Yes**	☐ **No** **If yes, please list type:**