Patient Medical History

Today's Date: ____________________

Patient information

Patient Name	Date of Birth	Birth Sex	Pronouns
		☐ M ☐ F	

Gender Identity
☐ Identifies as Male ☐ Identifies as Female ☐ Female-to-Male (FTM)/Transgender Male ☐ Male-to-Female (MTF)/Transgender Female
☐ Genderqueer, neither exclusively male nor female ☐ Additional gender category or other ☐ Choose not to disclose

Patient History

INDICATE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

- ☐ Head/brain injuries or illnesses (e.g., concussion)
- ☐ Seizures, epilepsy
- ☐ Eye problems (except glasses or contacts)
- ☐ Ear and or hearing problems
- ☐ Heart disease, heart attack, bypass, or other heart problems
- ☐ Pacemaker, stents, implantable devices, or other heart procedures
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Chronic (long-term) cough, shortness of breath or other breathing problems
- ☐ Lung disease (e.g., asthma)
- ☐ Kidney problems, kidney stones, or pain/problems with urination
- ☐ Stomach, liver or digestive problems
- ☐ Diabetes or blood sugar problems
- ☐ Anxiety, depression, nervousness, or other mental health problems
- ☐ Fainting or passing out
- ☐ Dizziness, headaches, numbness, tingling, or memory loss
- ☐ Unexplained weight loss
- ☐ Stroke, mini-stroke (TIA), paralysis, or weakness
- ☐ Neck or back problems
- ☐ Bone, muscle, joint or nerve problems
- ☐ Blood clots or bleeding problems
- ☐ Cancer
- ☐ Chronic (long term) infection or other chronic diseases
- ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring

Allergies (include medication, food, latex and environmental allergies)

No known allergies ☐

Allergy to:			
Severity:	☐ MIld ☐ Moderate ☐ Severe	☐ MIld ☐ Moderate ☐ Severe	☐ MIld ☐ Moderate ☐ Severe
Reaction:			

Current Medication (include non-prescription products)

No current medications ☐

1.	3.	5.	7.
2.	4.	6.	8.

Preferred Pharmacy

Are you interested in using the Doctors Care in-center pharmacy? ☐ Yes ☐ No

Pharmacy Name	Pharmacy Location

Procedures / Surgeries

No procedures or surgeries ☐

Surgery / Procedure #1	Approximate Date	Surgery / Procedure #3	Approximate Date
Surgery / Procedure #2	Approximate Date	Surgery / Procedure #4	Approximate Date

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Patient Medical History — Page 2

Today's Date: ____________________

Patient Name	Date of Birth

Preventative Screening

Not applicable ☐

Have you had a colonoscopy? ☐ Yes ☐ No If yes, date:

Have you had a mammogram? ☐ Yes ☐ No If yes, date:

Women's Health

Not applicable ☐

When was your most recent menstrual cycle? Date:

Family History

Mother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Father	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Sister	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Brother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A

Other Health Issues

Do you drink alcohol? ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor ____________ per week

Do you smoke cigarettes? ☐ Yes ☐ No If yes, ____________ per day, ____________ years of use

Do you use other forms of tobacco? ☐ Yes ☐ No ☐ Pipe ☐ Cigar ☐ Snuff/Chew

Do you vape or use an e-cigarette? ☐ Yes ☐ No If yes, ____________ per day, ____________ years of use

Marijuana / recreational drug use? ☐ Yes ☐ No If yes, ____________ per day, ____________ years of use

Immunizations

Influenza (18 years of age and older) ☐ Yes ☐ No If yes, date: ____________

Pneumoccal (65 years of age and older) ☐ Yes ☐ No If yes, date: ____________

Tetanus ☐ Yes ☐ No If yes, date: ____________

COVID-19 ☐ Yes ☐ No Number of shots: ____________ Date of most recent: ____________

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