



Patient Medical History

Today's Date: _____

Patient Name: _____

Date of Birth: _____

PATIENT HISTORY

No Past Conditions

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

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Anemia or other blood disease | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Kidney, bladder or prostate disease | <input type="checkbox"/> Blood clots | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (past or present) | <input type="checkbox"/> Depression | |

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

No Known Allergies

Allergy to: 1. _____ 2. _____ 3. _____

Severity: Mild Moderate Severe Mild Moderate Severe Mild Moderate Severe

Reaction: _____

CURRENT MEDICATION (include non-prescription products)

No Current Medication

- | | | | |
|----------|----------|----------|----------|
| 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: _____

Location: _____

PROCEDURES/SURGERIES

Approximate Date Surgery

Approximate Date Surgery

Approximate Date Surgery

Approximate Date Surgery

PREVENTATIVE SCREENING

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

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

WOMEN'S HEALTH

When was your last menstrual cycle?..... Date: _____



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FAMILY HISTORY

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