HealthCare Partners Medical Group

PATIENT HISTORY

Name: _____ Date of Birth: _____

Medical Record Number: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with any of the following?

	PATIENT HISTORY	FAMILY HISTORY
High Blood Pressure	____ Yes ____No	____ Yes ____No
Diabetes Mellitus (sugar)	____ Yes ____No	____ Yes ____No
Angina Pectoris (Chest Pain)	____ Yes ____No	____ Yes ____No
Heart Attack	____ Yes ____No	____ Yes ____No
Irregular Heart Beats	____ Yes ____No	____ Yes ____No
Hypertension	____ Yes ____No	____ Yes ____No
High Cholesterol	____ Yes ____No	____ Yes ____No
Blood Clots	____ Yes ____No	____ Yes ____No
Anemia (low blood count)	____ Yes ____No	____ Yes ____No
Stroke	____ Yes ____No	____ Yes ____No
Emphysema / COPD	____ Yes ____No	____ Yes ____No
Asthma	____ Yes ____No	____ Yes ____No
Other Breathing Problems: _____	____ Yes ____No	____ Yes ____No
Hepatitis	____ Yes ____No	____ Yes ____No
Hypothyroidism (Low Thyroid)	____ Yes ____No	____ Yes ____No
Arthritis	____ Yes ____No	____ Yes ____No
Kidney Stones	____ Yes ____No	____ Yes ____No
Rheumatic Fever	____ Yes ____No	____ Yes ____No
Ulcers (Bleeding)	____ Yes ____No	____ Yes ____No
Cataract	____ Yes ____No	____ Yes ____No
Glaucoma	____ Yes ____No	____ Yes ____No
TB / Positive Skin Test	____ Yes ____No	____ Yes ____No
Mental Health Treatment	____ Yes ____No	____ Yes ____No
Please Specify: _____		

Other, please specify:

_____

_____

Cancer:	____ Yes ____No	____ Yes ____No
What kind:_____		When?_____
What kind:_____		When?_____
What kind:_____		When? _____

Revised 07/2016

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PATIENT HISTORY

OBSTETRICS AND GYNECOLOGY HISTORY:

Last Menstrual Period: _____ Are you sexually active? _____Yes _____No
Please specify, if any, irregularities about your period:

_____

Child Birth: _____
Abortions, miscarriages, stillbirths, C-sections: _____

WHAT OTHER PROVIDERS DO YOU SEE? or HAVE YOU SEEN IN THE PAST?

Name: _____ Name: _____
Address:_____ Address: _____
Phone Number: _____ Phone Number: _____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Address:_____ Address: _____
Phone Number: _____ Phone Number: _____
Specialty: _____ Specialty: _____

PAST SURGICAL HISTORY:

Have you ever had any of the following operations? If so, when?

Appendectomy (Appendix)	_____Yes	_____No	_____ Date / Year
Tonsillectomy (Tonsil Removal)	_____Yes	_____No	_____ Date / Year
Cholecystectomy (Gallbladder)	_____Yes	_____No	_____ Date / Year
Hysterectomy (Uterus)	_____Yes	_____No	_____ Date / Year
Mastectomy (Breast Single or Bilateral)	_____Yes	_____No	_____ Date / Year
Bypass Surgery (Heart)	_____Yes	_____No	_____ Date / Year
Cataract Laser	_____Yes	_____No	_____ Date / Year
Hemorrhoidectomy (Hemorrhoids)	_____Yes	_____No	_____ Date / Year
Colectomy (Colon Removal)	_____Yes	_____No	_____ Date / Year
Hernia Repair	_____Yes	_____No	_____ Date / Year
Anesthesia Complications	_____Yes	_____No	_____ Date / Year

Other, please specify:
_____
_____

Recent ER Visit/Hospitalization? _____Yes _____No _____ Date
Date:_____ Reason: _____

Patient Name: _____
Date of Birth: _____
MRN: _____

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PATIENT HISTORY

PRIOR EXAMS and IMMUNIZATIONS:

DATES

Exam	1	2	3
Periodic Health Exam			
EKG			
Cholesterol Test			
Chest X-ray			
Pap Smear			
Mammogram (Breast Exam)			
Prostate Exam			
Colonoscopy			
Sigmoidoscopy			
Stool Test (FOBT)			
Bone Mineral Density Test			
Diabetic Eye Exam			
Dental Exam			
Glaucoma Screening			

DATE OF DOSE (mm/dd/yy)

Vaccine	1	2	3	4	5
Polio					
DTP					
DT or Td					
MMR					
HIB Meningitis					
Mumps					
Rubella					
Measles					
Chicken Pox					
Tetanus					
HPV					
Pneumovax					
Hepatitis					
Zostavax					

Do you need any immunizations today? _____Yes _____No

CURRENT MEDICATIONS:

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

**Add additional medications to the back of this form*

Patient Name: _____

Date of Birth: _____

MRN: _____

Revised 7/2016

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PATIENT HISTORY

ALLERGIES:

Seasonal _____ Yes _____No Animals _____ Yes _____No

Medication _____ Yes _____No

Medicine: _____ Type of Reaction: _____

Medicine: _____ Type of Reaction: _____

Medicine: _____ Type of Reaction: _____

SOCIAL HISTORY:

Do you smoke? _____ Yes _____No How much/How long? _____

If stopped, how long ago? _____

Do you drink Alcohol? _____ Yes _____No How much? _____

If stopped, how long ago? _____

Substance Abuse? _____ Yes _____No How much? _____

If stopped, how long ago? _____

Do you exercise regularly? _____ Yes _____No How much? _____

Are you on any special diet? _____ Yes _____No What diet? _____

Do you need any special assistance?

_____ Yes _____No What kind? _____

Have you traveled outside of the country recently?

_____ Yes _____No What kind? _____

Do you live in more than one location throughout the year?

_____ Yes _____No

***Please remember to provide us with any alternate contact and provider information

Do you have Advanced Directives / Living Will _____Yes _____No

***Please bring a copy for your provider

_____ _____

DATE PATIENT SIGNATURE

Patient Name: _____

Date of Birth: _____

MRN: _____