HealthCare Partners
Medical Group

PATIENT HISTORY

PERSONAL DATA

Name: ____________________ Date of Birth: ____________________

Social Security: ____________________ Age: ____________________

Phone Number (Home): ____________________ Marital Status: ____________________

Occupation: ____________________ Work#: ____________________

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	____ Yes	____ No	____ Yes	____ No
Heart Attack	____ Yes	____ No	____ Yes	____ No
High Cholesterol	____ Yes	____ No	____ Yes	____ No
Blood Clots	____ Yes	____ No	____ Yes	____ No
Stroke	____ Yes	____ No	____ Yes	____ No
Emphysema	____ 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
Cancer	____ Yes	____ No	____ Yes	____ No
Anemia (low blood count)	____ 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
Irregular Heart Beats	____ Yes	____ No	____ Yes	____ No
TB	____ Yes	____ No	____ Yes	____ No
Hypertension	____ Yes	____ No	____ Yes	____ No

Others, please specify:

____

____

Cancer ____ Yes ____ No

What kind? ____________________ When? ____________________

What kind? ____________________ When? ____________________

What kind? ____________________ When? ____________________

PAST MEDICAL / SURGICAL HISTORY

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

Operation	Yes	No	Year
Appendectomy	_____ Yes	_____ No	_____ Year
Tonsillectomy	_____ Yes	_____ No	_____ Year
Gallbladder Removal	_____ Yes	_____ No	_____ Year
Hysterectomy	_____ Yes	_____ No	_____ Year
Bypass Surgery	_____ Yes	_____ No	_____ Year
Cataract Laser	_____ Yes	_____ No	_____ Year
Hemorrhoidectomy	_____ Yes	_____ No	_____ Year
Hernia Repair	_____ Yes	_____ No	_____ Year
Colon Cancer Screening	_____ Yes	_____ No	_____ Year
Colonoscopy/Sigmoidoscopy	_____ Yes	_____ No	_____ Year
Bone Mineral Density Test	_____ Yes	_____ No	_____ Year
PSA Screening	_____ Yes	_____ No	_____ Year
Pneumovax	_____ Yes	_____ No	_____ Year

Others, please specify:

____

____

____

Do you have an Advance Directive / Living Will _______ Yes ________ No Please bring a copy for your provider

PREVIOUS PHYSICIANS

Name: ____

Address: ____

Phone Number: ____

Name: ____

Address: ____

Phone Number: ____

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 ________

Medicine ____________________ Dose (Mg) ____________ How often ________

ALLERGIES

Seasonal _____ Yes _____ No

Animals _____ Yes _____ No

Medications _____ Yes _____ No

Medicine ________________________ Type of Reaction ____________________

Medicine ________________________ Type of Reaction ____________________

Medicine ________________________ Type of Reaction ____________________

PRIOR EXAMS AND IMMUNIZATIONS

DATES

EXAMS & TESTING	1	2	3
Periodic Health Exam			
EKG			
Stool/Occult Blood			
Cholesterol			
PAP			
Mammogram			
CXR			
Influenza (Flu Shot)			
TB Tine			
Sigmoidoscopy			
Breast Exam			
Preventive Care Counseling			

DATE OF DOSE (mo/day/yr)

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

Do you need any immunizations today? _____Yes _____ No

PROSTATE EXAMINATION

Last Rectal Examination: ______________________________

Last PSA Test: ______________________________

Results if known: ______________________________

OBSTETRICS AND GYNECOLOGY HISTORY

Last Menstrual Period: ______________________________

Please specify, if any, irregularities about your period:

____

____

____

Child Birth: ______________________________

Abortions, miscarriages, stillbirths, c/section: ______________________________

SOCIAL HISTORY

Smoking ____ Yes ____ No

How much? ________________________ If stopped, how long ago? ________________

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

Are you on any special diet? ____ Yes ____ No

Do you need any special assistance? ____ Yes ____ No

What kind? ____

Have you traveled outside the state or country recently? ____ Yes ____ No

Where? ____

LIVING WILL

Please provide a copy, if possible ____ Yes ____ No

______________________ DATE

______________________ SIGNATURE