Colonial HEALTHCARE

Chart #: _____

Today's Date: _____

Patient Medical History Form

Last Name: _____ **First Name:** _____ **Age:** _____ **Sex:** _____

DOB: _____/_____/_____ **Pharmacy:** _____ **Primary Doctor:** _____

Medications

Please list any medications that you are now taking. Include non-prescription medications:

Name of drug	Dose (mg, pill, etc.)	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

Medical History

Do you now or have you ever had:

- ❑ Diabetes (type) _____
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ ADD/ADHD
- ❑ Cancer (type) _____
- ❑ Blood Clots (DVT)
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Arthritis
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Concussion
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Depression
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Heart Failure
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Diverticulitis
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Anxiety
- ❑ Gout

Other medical conditions (please list):

Allergies

❑ **NO ALLERGIES**

Allergies to Medications or Other Substances	Type of Reaction

Surgical History

Chart #: _____

Type (specify left/right)	Date	Location/Facility

Hospitalization

Reason	Date	Location/Facility

Family History

List hereditary medical conditions of family members regardless of whether alive or deceased.

CHECK ALL THAT APPLY	Age, if living	High Blood Pressure	Diabetes	Cardiovascular Disease	Abuse, Drug or Alcohol	Mental Illness	Cancer	High Cholesterol	Heart Disease	Heart Attack	Stroke	Depression	Anxiety	Asthma	Kidney Disease	Other: _____	Other: _____
Daughter(s)																	
Father																	
Brother																	
Sister																	
Son(s)																	
Mother																	
Paternal Grandfather																	
Paternal Grandmother																	
Maternal Grandfather																	
Maternal Grandmother																	

Additional Information

Have you traveled outside of the country in the last 30 days? ❑ **YES** ❑ **NO** If yes, where? _____

Have you served in the military? ❑ **YES** ❑ **NO** If yes, how long, and what branch? _____

Were you deployed? ❑ **YES** ❑ **NO** If yes, where? _____

Environmental/Occupational Exposure:

Are you exposed to any of the following? ❑ **Secondhand Smoke** ❑ **Asbestos** ❑ **Chemicals/Pesticides**

Vaccination History

Last Tetanus Booster or TdaP:	Last Pnuemovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	Last Hepatitis B Series:

Social History

Chart #: _____

Are you a current or former smoker? ❑ **Never** ❑ **Current Smoker*** ❑ **Former Smoker****

***If current smoker, answer the following questions**

When did you start smoking? _____ How often do you smoke? ❑ **Every Day** ❑ **Some Days**

How many cigarettes a day do you smoke? ❑ **5 or less** ❑ **6-10** ❑ **11-20** ❑ **21-30** ❑ **31 or more**

How soon after you wake up do you smoke your first cigarette?
❑ **within 5 minutes** ❑ **6-30 minutes** ❑ **31-60 minutes** ❑ **after 60 minutes**

Are you interested in quitting? ❑ **Ready to quit** ❑ **Thinking about quitting** ❑ **Not ready to quit**

****If former smoker, answer the following questions**

When did you start smoking? _____ When did you stop smoking? _____

How long has it been since you last smoked? ❑ **1-3 months** ❑ **<1 month** ❑ **3-6 months**
❑ **6-12 months** ❑ **1-5 years** ❑ **5-10 years** ❑ **>10 years** ❑ **10-15 years >20 years**

Advance Directive: Living Will ❑ **YES** ❑ **NO** Power of Attorney: ❑ **YES** ❑ **NO** Code Status: ❑ **Full Code** ❑ **DNR**
If yes, please bring copy

Sexual History: Had sex in the past 12 months? ❑ **YES** ❑ **NO** with ❑ **Men Only** ❑ **Women Only** ❑ **Both Men and Women** Use Protection? ❑ **YES** ❑ **NO** Prevention strategies discussed: ❑ **Abstinence** ❑ **Condoms** ❑ **Other** Have you ever had a sexually transmitted disease? - ❑ **YES** ❑ **NO** Chlamydia? - ❑ **YES** ❑ **NO** GC? - ❑ **YES** ❑ **NO** Syphilis? - ❑ **YES** ❑ **NO** Herpes? - ❑ **YES** ❑ **NO** Other? - ❑ **YES** ❑ **NO**

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Separated** ❑ **Widowed** ❑ **Partner** ❑ **Other: _____**
Number of Adults in Household: _____ Number of Children in Household: _____ Religion: _____

Occupation: ❑ **Retired** ❑ **Unemployed** ❑ **Disabled** Employer: _____
Years of Education or Highest Degree: _____

Do you drink alcohol? ❑ **YES** ❑ **NO** If yes, please answer the following:

How often did you drink alcohol in the past year?
❑ **Never** ❑ **Monthly or less** ❑ **2 to 4 times a month** ❑ **2 to 3 times a week** ❑ **4 or more times a week**

How many drinks did you have on a typical day when you were drinking in the past year?
❑**1 or 2 drinks** ❑ **3 or 4 drinks** ❑ **5 or 6 drinks** ❑ **7 to 9 drinks** ❑ **10 or more drinks**

How often did you have 6 or more drinks on one occasion in the past year?
❑ **Never** ❑ **Less than monthly** ❑ **Monthly** ❑ **Weekly** ❑ **Daily or almost daily**

Have you used drugs other than those for medical reasons in the past 12 months? ❑ **YES** ❑ **NO**

Caffeine use: ❑ **Never** ❑ **Occasionally** ❑ **Weekly**

Women's Health History

Date of Last Menstrual Cycle: _____ Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies: _____ Number of Live Births: _____ Pregnancy Complications:_____
_____

Health Maintenance Test

Cholesterol	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**
Colonoscopy	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**
Mammogram	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**
Pap Smear	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**
Bone Density	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**
EKG	Date:	Facility/Provider:	Abnormal Result? ❑**Yes** ❑**No**

Office Use Only: