Please take time to fill out this form.
Thank you for trusting us with your care.

Date Completed_____
Name_____ Date of Birth_____
Form Completed by □Self □Other:_____
Preferred Pharmacy_____
Reason for Visit_____
Email address _____
Preferred method of communication:
□ Email □ Phone □ Mail

PATIENT MEDICAL HISTORY

□ Blood Disease	□ Heart Disease	□ Osteoporosis
□ Breast Disease	□ High Blood Pressure	□ Rheumatology/Arthritis
□ Cancer	□ HIV	□ Skin Problems
□ Diabetes/Thyroid Problems	□ Kidney Problems	□ Stroke/Seizures
□ Female Problems	□ Lung Problems (COPD, Asthma)	□ Stomach Problems
□ Head, Eyes, Ear, Nose, Throat	□ Male Problems	□ STI/STD
	□ Mental Illness	□ Other

LAST SPECIALTY VISIT/HOSPITALIZATION/SURGERY

Reason Date

_____

_____

□ None

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Don't Know
Bleeding Problems	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes/Thyroid Problems	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□
Kidney Problems	□	□	□	□	□	□	□
Mental Illness /Depression	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□
Stroke/Seizures	□	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□	□

PREGNANCY HISTORY

Currently Pregnant □ Yes □No □Not Applicable

Past Pregnancies #_____ Dates (Month/Year)_____ Abortions/Miscarriages # _____

MEDICATION

List any prescription and non-prescription medication you take regularly (include OTC, herbals, vitamins, etc.)

_____

_____

_____

_____

ALLERGIES

Allergies **Reaction**

_____

_____

□ No Known Allergies

IMMUNIZATION (SHOT) HISTORY

	Date (Mo/ Yr)	Where
□ Flu		
□ Pneumonia		
□ Tetanus		
□ Hep A		
□ Hep B		

WELL CARE

	Date (Mo/Yr)	Results		Where
Last Menstrual Cycle				
	_____			
Last PAP test	_____	□ Normal	□ Abnormal	_____
Last Mammogram	_____	□ Normal	□ Abnormal	_____
Colonoscopy	_____	□ Normal	□ Abnormal	_____
Prostate Cancer Screening	_____	□ Normal	□ Abnormal	_____
TB Screening	_____	□ Normal	□ Abnormal	_____
HIV Screening	_____	□ Normal	□ Abnormal	_____
Hep C Screening	_____	□ Normal	□ Abnormal	_____

HEALTH HABITS

□ Tobacco	□ Cigarettes ____ packs/day □ Interest in stopping	□ Cigars/Pipes □ No interest in stopping	□ Chew/Dip
□ Alcohol	Amount _____ _____/day		
□ Physical Activity	Minutes_____/day	# Days____/week	
□ Caffeine	Cups_____/day		
□ Sexual Activity	□ Inactive	□ One Partner	□ More than one partner
□ Seatbelt use	□ Always	□ Sometimes	□ Never
Are you satisfied with your eating habits?		□ yes	□ no

SOCIAL CONSIDERATIONS

Are there any religious/ cultural consideration regarding your care? □ yes □ no

If yes, please explain _____

Are you having any experiences at home that make you feel unsafe? □ yes □ no

If yes, please explain _____

Preferred Language _____

LEARNING NEEDS ASSESSMENT

Do you have any of the following?

Learning disabilities	□ yes	□ no
Visual limitations	□ yes	□ no
Hearing limitations	□ yes	□ no

If yes, please explain _____

Required Accomodations_____

Behavioral Health Questionnaire (PHQ-2)

Please help us provide you with the best medical care by answering the questions below.

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
During the past two weeks, how often have you been bothered by little interest or pleasure in doing things?	0	1	2	3
During the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?	0	1	2	3

Drug & Alcohol Screening

Are you currently in recovery for alcohol or substance use? _____ No _____ Yes
(0) (1)

Alcohol: One drink = 

12 oz. Beer  5 oz. Wine  1.5 oz. Liquor (One Shot)

		None	1 or more
Men < 65	How many times in the past year have you had 5 or more drinks in a day?	0	1
Women (& Men > 65)	How many times in the past year have you had 4 or more drinks in a day?	0	1

Drugs: Recreational drugs include cannabis (marijuana, pot), cocaine, stimulants (Ritalin, Concerta, Adderall), methamphetamine (speed, crystal), inhalants (paint thinner, aerosol, glue), sedatives (Valium, Xanax, Rohypnol), hallucinogens (LSD, mushrooms, ecstasy), street opioids (heroin). Prescription opioids include fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine.

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	0	1

Office Use Only PHQ-2 _____ *Screen + if Score >2* D&A Screen_____ *Screen + Score >0*

Height_____Weight_____BMI_____WC_____

BP_____ Pulse_____ Resp_____ Temp_____

INR_____ BS_____HbgA1C_____O2Sat_____