Past Medical History

Patient Name: _____ DOB: _____ Date: _____

Pharmacy Name & Location: _____

Previous PCP: _____ Reason for Leaving: _____

How did you hear about us? _____

Past Medical History: Please check if you have had the following:

Cardiovascular
- □ High Blood Pressure
- □ Heart Attack, Year: _____
- □ High Cholesterol
- □ Atrial Fib
- □ Congestive Heart Failure (CHF)
- □ Blood Clots
- □ Peripheral Vascular Disease

Endocrinology
- □ Diabetes
- □ Thyroid Disease
- □ Pituitary Disorder
- □ Adrenal Disorder
- □ Testosterone Deficiency

Pulmonary
- □ COPD/Emphysema
- □ Asthma
- □ Sleep Apnea
- □ Pulmonary Nodule

Neurology
- □ Stroke, Year: _____
- □ Dementia
- □ Epilepsy/Seizure Disorder
- □ Migraine Headaches
- □ Pseudotumor Cerebri
- □ Restless Legs Syndrome
- □ Bell's Palsy
- □ Multiple Sclerosis
- □ Vertigo
- □ Tinnitis

Gastroenterology
- □ Acid Reflux/GERD
- □ Liver Disease/Hepatitis
- □ Celiac Disease
- □ Ulcerative Colitis
- □ IBS
- □ Diverticulosis

Nephrology
- □ Chronic Kidney Disease
- □ Kidney Stones

Hematology/Oncology
- □ Anemia
- □ Sickle Cell Disease/Trait
- □ Bleeding Disorder
- □ Cancer
  Type: _____

Psychiatry
- □ Depression
- □ Anxiety
- □ Bipolar
- □ Insomnia
- □ ADD/ADHD
- □ PTSD
- □ Schizophrenia

Rheumatology
- □ Rheumatoid Arthritis
- □ Lupus
- □ Fibromyalgia
- □ Osteoporosis
- □ Scleroderma

Infectious Disease
- □ +HIV or AIDS
- □ Tuberculosis
- □ COVID 19
- □ Herpes

Gynecology
- □ PCOS
- □ Endometriosis
- □ Uterine Fibroids
- □ Menopause

Urology
- □ BPH
- □ Erectile Dysfunction

Ophthalmology
- □ Glaucoma
- □ Cataracts

Dermatology
- □ Eczema
- □ Psoriasis
- □ Rosacea
- □ Acne

Orthopedic
- □ Carpal Tunnel Syndrome
- □ Chronic Pain
  Where? _____

Allergy/Immunology
- □ Environmental/Seasonal Allergies
- □ Immunodeficiency

Other: _____

_____

If you are **diabetic**, when was your last HgbA1C? _____ Result? _____

When was your last dilated eye exam? _____

What was the result? _____

Who was the ophthalmologist/optometrist? _____

When was your last diabetic foot exam? _____

Exam		Date of Last Exam	Result	Location	Doctor
Pap Smear	(ages 21-65)				
Mammogram	(ages 40-75)				
Bone Density	(over 65)				
Colonoscopy	(over 50)				
PSA	(over 50)				

Continued .....

Past Medical History (continued) Patient Name: _____

Immunizations: Please indicate if you have had the following immunizations and the approximate year

	Yes	No	Year		Yes	No	Year
Pneumovax (age > 65)	Yes	No	_____	Shingrix (age>50)	Yes	No	_____
Prevnar (age > 65)	Yes	No	_____	Tetanus (every 10 yrs)	Yes	No	_____
Flu (yearly)	Yes	No	_____	HPV (age 11-26)	Yes	No	_____
Covid (P,M,J&J)	Yes	No	_____				

Please list any specialists. (ex. Cardiology, Pulmonary, Neurology, Nephrology, Endocrinology, Gastroenterology, Rheumatology, Pain Management, OBGYN, Ophthalmology, Urology, ENT, Podiatry)

Diagnosis	**Specialist Type**	**Name**

Allergies: Please list all drug allergies and/or other allergies

Drug	**Reaction**

Medications: Please list all current medications (including over-the-counter medications), dosages, how you take them and who prescribes them

Medication	**Dosage**	**Frequency**	**Prescribing Dr.**

Continued .....

Past Medical History (continued) Patient Name: _____

Surgeries

Date	Surgery	Reason

Hospitalizations (other than those associated with surgeries listed above)

Date	Hospital	Reason

Tobacco Use

Are you a □ current smoker □ former smoker □ nonsmoker

If you are a **current or former smoker**, please list how many packs per day: _____

and for how many years: _____ . Quit date: _____

Have you had screening for an Abdominal Aortic Aneurysm? Yes _____ No_____

Have you had screening for Lung Cancer by Chest CT? Yes _____ No_____

Sexual History:

Have you had sex in the past 12 months?_____

Have you ever had an STD?_____

If yes, which one?_____ When? _____

Any history of sexual abuse? Yes _____ No_____

Have you used **drugs** other than those for medical reasons in the past 12 months? Yes _____ No _____

If yes, What drug? _____ How often? _____

Have you had a drink containing **alcohol** in the past 12 months? Yes_____ No_____

If yes, How often? _____ How many at each sitting? _____

How often have you had 6 or more drink on one occasion in the past year? _____

Describe your average daily caffeine intake: _____

Describe any regular exercise: _____

Describe your living situation, including who you live with: _____

_____

What is your Martial Status? _____Partner's Name: _____

What is your **occupation**? _____

Any known exposures? _____

Past Medical History (continued) Patient Name: _____

Family History

Members	Status (alive/deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	Stroke	Kidney Disease	Mental Illness (type)	Cancer (type)	Other
Mother										
Father										
Mom's Dad										
Mom's Mom										
Dad's Dad										
Dad's Mom										
Siblings										
Son(s)										
Daughter(s)										

How many siblings do you have? Brothers _____ Sisters_____
How many children do you have? Boys _____ Girls _____

Depression Screening

Do you have little interest or pleasure in doing things? Yes _____ No_____
Do you feel down, depressed or hopeless? Yes _____ No_____

If you answered **YES**, to either of the above questions, complete the following:

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

(Staff Only: if PHQ9>9 add CPT F34.1, Document Intervention)

Fall Risk Assessment

If you are **65 years of age or older**, please answer the following:

Have you fallen within the last 6 months? Yes _____ No_____
Do you have a history of falls? Yes _____ No_____
Do you take precautions to prevent falls? Yes _____ No_____
Are you taking any medications that might affect your balance? Yes _____ No_____