



# CENTER FOR PRIMARY CARE

## FAMILY MEDICINE

### PATIENT HEALTH HISTORY (Confidential)

*If completing form by hand, please print*

- CPC-Central
- CPC-Crossroads
- CPC-Evans
- CPC-North Augusta
- CPC-South

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_  
mm / dd / yyyy

Marital status \_\_\_\_\_ Occupation \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

#### HEALTH MAINTENANCE *List the most recent date for each of the following:*

| WOMEN ONLY             | BOTH MEN AND WOMEN        | MEN ONLY                        |
|------------------------|---------------------------|---------------------------------|
| _____ Menstrual period | _____ Cholesterol testing | _____ Pneumonia vaccine         |
| _____ Mammogram        | _____ Colonoscopy         | _____ Bone Density (DEXA)       |
| _____ Pap smear        | _____ Tetanus booster     | _____ Digital rectal exam       |
|                        |                           | _____ PSA (prostate blood test) |

#### CONDITIONS *Check conditions you currently have or have had in the past*

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> GERD (reflux)       | <input type="checkbox"/> HIV positive       | <input type="checkbox"/> Rhinitis                       |
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> CAD / heart disease | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Cancer, type _____  | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Suicide attempt                |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Thyroid problem                |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Depression          | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Prostate problem   | <input type="checkbox"/> Ulcer(s)                       |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Emphysema/COPD      | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Psychiatric care   | <input type="checkbox"/> Vaginal infections             |
| <input type="checkbox"/> Breast lump       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever    |   |
| <input type="checkbox"/> Other _____       |  |  |   |   |

#### ALLERGIES? *Check appropriate box below. If yes, please list all known allergies to medications or substances*

- No known allergies  Yes, I have the following allergies:

#### MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

#### HEALTH HABITS *Check appropriate boxes below and describe*

|            |                                 |  |
|------------|---------------------------------|--|
| Caffeine   | <input type="checkbox"/> None   | <input type="checkbox"/> _____ drinks per _____  |
| Tobacco    | <input type="checkbox"/> None   | <input type="checkbox"/> _____ cigarettes per day <input type="checkbox"/> Quit smoking around _____ |
| Alcohol    | <input type="checkbox"/> None   | <input type="checkbox"/> _____ drinks per _____  |
| Drugs      | <input type="checkbox"/> None   | <input type="checkbox"/>   |
| Diet       | Describe: _____                 |  |
| Exercise   | Describe: _____                 |  |
| Seat belts | <input type="checkbox"/> Always | <input type="checkbox"/> Never <input type="checkbox"/> Sometimes                                    |

(Continued on back)

| SURGICAL HISTORY |                         |   | PREGNANCY HISTORY                              |        |                       |
|------------------|-------------------------|---|--|--------|-----------------------|
| Year             | Hospital / City / State | Type of surgery / complications, if any | # pregnancies _____ ; # living children _____  |        |                       |
|                  |                         |   | # deliveries: C-sections _____ ; vaginal _____ |        |                       |
|                  |                         |   | Birth year                                     | M or F | Complications, if any |
|                  |                         |   |  |        |                       |
|                  |                         |   |  |        |                       |
|                  |                         |   |  |        |                       |
|                  |                         |   |  |        |                       |
|                  |                         |   |  |        |                       |
|                  |                         |   |  |        |                       |

**OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES**

| Year | Hospital / City / State | Reason for hospitalization, nature of illness or injury |
|------|-------------------------|---|
|      |                         |   |
|      |                         |   |
|      |                         |   |
|      |                         |   |
|      |                         |   |

Have you ever had a blood transfusion?  No  Yes Date(s): \_\_\_\_\_

**FAMILY HISTORY**

Fill in information about your family below:

Check  if a blood relative has had any of the following:

| Relation | Age, if living | Age at death | Medical conditions / cause of death | Disease                                      | Relationship to you |
|----------|----------------|--------------|-------------------------------------|--|---------------------|
| Father   |                |              |                                     | <input type="checkbox"/> Arthritis           |                     |
| Mother   |                |              |                                     | <input type="checkbox"/> Asthma              |                     |
| Brothers |                |              |                                     | <input type="checkbox"/> Cancer              |                     |
|          |                |              |                                     | <input type="checkbox"/> Diabetes            |                     |
|          |                |              |                                     | <input type="checkbox"/> Gout                |                     |
|          |                |              |                                     | <input type="checkbox"/> Heart disease       |                     |
| Sisters  |                |              |                                     | <input type="checkbox"/> High blood pressure |                     |
|          |                |              |                                     | <input type="checkbox"/> Kidney disease      |                     |
|          |                |              |                                     | <input type="checkbox"/> Stroke              |                     |
|          |                |              |                                     | <input type="checkbox"/> Other               |                     |

**ADDITIONAL INFORMATION** *What else do you think your doctor should know about your health?*

*I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.*

Patient Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_ Date \_\_\_\_\_