Patient Medical History

Today's Date: ____________

Patient Name: ____________ Date of Birth: ____________

PATIENT HISTORY

No Past Conditions ☐

CHECK ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

☐ Heart disease	☐ Anemia or other blood disease	☐ Severe headaches	☐ Neck pain
☐ High blood pressure	☐ Thyroid disease	☐ Seizures	☐ Back pain
☐ High cholesterol	☐ Stomach disease	☐ Stroke	☐ Sleep apnea
☐ Lung disease	☐ Kidney, bladder or prostate disease	☐ Blood clots	☐ ____________
☐ Diabetes	☐ Cancer (past or present)	☐ Depression	

ALLERGIES (include medication, food, latex and environmental allergies)

No Known Allergies ☐

Allergy to:	1. ____________	2. ____________	3. ____________
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:	____________	____________	____________

CURRENT MEDICATION (include non-prescription products)

No Current Medication ☐

1. ____________	3. ____________	5. ____________	7. ____________
2. ____________	4. ____________	6. ____________	8. ____________

PREFERRED PHARMACY

Are you interested in using the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No

Pharmacy Name: ____________ Location: ____________

PROCEDURES/SURGERIES

____________	____________
Approximate Date Surgery	Approximate Date Surgery
____________	____________
Approximate Date Surgery	Approximate Date Surgery

PREVENTATIVE SCREENING

Have you had a colonoscopy?............ ☐ Yes ☐ No If yes, date: ____________

Have you had a mammogram?............ ☐ Yes ☐ No If yes, date: ____________

WOMEN'S HEALTH

When was your last menstrual cycle?............ Date: ____________

Patient Medical History — Page 2

Today's Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

FAMILY HISTORY

Mother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Father:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Sister:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Brother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Grandmother (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Grandmother (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Grandfather (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A
Grandfather (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) ______	☐ N/A

OTHER HEALTH ISSUES

Do you drink alcohol?........ ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor ______ per week

Do you smoke cigarettes?........ ☐ Yes ☐ No If yes, ______ per day, ______ years of use

Do you use other forms of tobacco?..... ☐ Yes ☐ No ☐ Pipe ☐ Cigar ☐ Snuff/Chew

Do you use an e-cigarette?........ ☐ Yes ☐ No If yes, ______ per day, ______ years of use

Marijuana / recreational drug use?..... ☐ Yes ☐ No If yes, ______ per day, ______ years of use

IMMUNIZATIONS

Influenza (18 years of age and older)?........ ☐ Yes ☐ No If yes, date: ______

Pneumoccal (65 years of age and older)?........ ☐ Yes ☐ No If yes, date: ______

Tetanus?........ ☐ Yes ☐ No If yes, date: ______