NORTH POINT PHYSICIANS LLC

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: ____/____/____ Sex: Female / Male

PAST MEDICAL HISTORY - *Please list all known medical conditions (past and present)*

EXAMPLE: *diabetes*

1_____ 6_____
2_____ 7_____
3_____ 8_____
4_____ 9_____
5_____ 10_____

SURGICAL/HOSPITALIZATION HISTORY – *Please list all surgeries and hospitalizations.*

SURGERY/HOSPITALIZATION	DATE	BRIEF EXPLANATION
EXAMPLE: *hysterectomy*	*1978*	*fibroid tumors were bleeding*
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____
5_____	_____	_____

ALLERGY HISTORY – *Please list all known medication, food, and environmental allergies.*

ALLERGY	REACTION
EXAMPLE: *penicillin*	*hives and rash as a child*
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____

MEDICATION HISTORY – *Please list **ALL** medications you are currently taking.*

EXAMPLE: *Atenolol 50mg twice daily*

1_____ 6_____
2_____ 7_____
3_____ 8_____
4_____ 9_____
5_____ 10_____

NAME _____ DOB: _____

FAMILY HISTORY

Mother: AGE _____ living / deceased / unknown

Medical conditions_____

Father: AGE _____ living / deceased / unknown

Medical conditions_____

Siblings:

AGE(S)_____

Medical conditions_____

Children:

AGE(S)_____

Medical conditions_____

SOCIAL HISTORY

Occupation: _____
Religious preference:_____
Exercise Routine:_____

Which best describes you? (Check one)

_____SMOKER
Number of packs/day? _____ Number of years? _____
_____FORMER SMOKER
Number of packs/day? _____ Number of years? _____
When did you quit? _____
_____NEVER SMOKED

Which best describes your drinking habits? (check one)

_____ NON-DRINKER

_____ RECOVERING ALCOHOLIC quit date _____

_____ RARE ALCOHOL USE
Number of drinks per night?_____ week?_____ month?_____
_____ MODERATE ALCOHOL USE
Number of drinks per night?_____ week?_____ month?_____
_____ SOCIAL ALCOHOL USE
Number of drinks per night?_____ week?_____ month?_____
_____ HEAVY ALCOHOL USE
Number of drinks per night?_____ week?_____ month?_____

Drug Use

Do you use any recreational drugs? Yes / No

Have you ever used or shared needles? Yes / No

NAME _____ DOB: _____

Advance Directive

Advanced Directive? Yes / No (*if Yes, Please provide copy to us)*

Immunizations *(list dates):*

Hepatitis B:	Influenza:
Td-Adult Tetanus Toxoid:	Pneumonia Shot:
PPD –Tuberculin Skin Test:	Shingles Shot:

Have you been exposed to someone with Tuberculosis? YES / NO

MALES ONLY

Date of most recent PSA blood test _____/_____/_____
Date of most recent rectal/prostate examination _____/_____/_____

FEMALES ONLY

Date of last menstrual period _____/_____/_____
Total number of pregnancies _____
How many were full term deliveries? _____
How many were pre-term deliveries? _____
How many were miscarried/terminated? _____
Date of most recent pap smear _____/_____/_____
Have you ever had an abnormal pap smear in the past? YES / NO
Date of last mammogram _____/_____/_____
Have you ever had an abnormal mammogram? YES / NO

Please list names of other physicians you see in our area (including specialists):

_____

_____

NOTE: This is a confidential record of your medical history. This information will not be released to any person without your prior written consent.

PROVIDER REVIEWED _____DATE ____/____/____