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 ____/____/____