Patient Medical History Intake Form **CareMedica**

Patient Name:_____DOB:_____/_____/_____Date:_____

Reason for Today's Visit:

- ❑ New Patient
- ❑ Illness
- ❑ Work Injury
- ❑ Auto Accident
- ❑ Medically Supervised Weight Loss Program
- ❑ Pre-Surgical Clearance
- ❑ Hospital Discharge Follow-Up

Height:_____Weight:_____ **Mail Order Pharmacy:_____**

Preferred Pharmacy:_____

Allergies and sensitivities to medications, food, animals, other. Please include the reactions:_____
_____
_____
_____

- ❑ No known allergies

ALL current medications (List all prescription and non-prescription medications, contraceptives, vitamins, and supplements):

Medication Name	**Frequency**	**As of**	**Prescriber**

- ❑ Not taking medications

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia			HIV/AIDS/Hepatitis		
Asthma			Hypo/Hyperthyroidism		
Blood Clot/DVT			Lyme Disease		
Cancer:			Osteoporosis/Osteopenia		
COPD			Peripheral Vascular Disease		
Diabetes Type I/Type II			Psoriasis		
Gout			Renal Failure/Kidney Disease		
Heart Attack/Angina			Rheumatoid Arthritis/Lupus		
Heart Disease/Pacemaker			Stroke		
High Blood Pressure			Tuberculosis		
History of Blood Transfusion			Ulcer/Acid Reflux/GERD		
History of Prednisone or Steroid Medication			Other:		

PAST SURGERIES	REASON	SURGEON	DATE

PAST HOSPITALIZATIONS	REASON	DATE

Preventative Care

Please list the date of your most recent; if unknown please check unknown:

Complete physical	Date:_____	❒Unknown
Tuberculosis Test	Date:_____	❒Unknown
Tetanus Immunization	Date:_____	❒Unknown
Prevnar 13	Date:_____	❒Unknown
Pneumovax 23	Date:_____	❒Unknown
Shingles	Date:_____	❒Unknown
HPV	Date:_____	❒Unknown
Meningitis	Date:_____	❒Unknown
TDAP	Date:_____	❒Unknown
Influenza Immunization	Date:_____	❒Unknown
Measles Immunization	Date:_____	❒Unknown
Hepatitis A and or B Immunization	Date:_____	❒Unknown
Colonoscopy	Date:_____	❒Unknown
Dental Cleaning	Date:_____	❒Unknown
Eye Exam	Date:_____	❒Unknown

Family History

Relationship	**Living or Deceased?**	**Please list any inherited diseases, chronic illness or cause of death**
Mother		
Father		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

Brothers		
Sisters		
Sons		
Daughters		

Social History

Marital Status: ❒ Single ❒Married ❒ Divorced ❒Widowed

What do you consider your stress level is? ❒ Low ❒ Medium ❒High

Do you have a family history of medical, mental, or hereditary problems? ❒Yes ❒No
Please list:_____
_____
_____

Travel Outside the U.S within the past three years? ❒Yes ❒No
Where and when?_____

Do you have a living will? ❒Yes ❒No

Is your time well balanced between your jobs, family and hobbies? ❒Yes ❒No

Do you wear seat belts? ❒Always ❒Usually ❒Occasionally ❒Never

If you ride a bicycle or motorcycle, do you wear a bike helmet? ❒Yes ❒No

Do you have frequent falls? ❒Yes ❒No

If there is a gun in your home, is it out of children's reach and unloaded? ❒Yes ❒No

If you are a female, do you do a monthly self-breast exam? ❒Yes ❒No

If you are a male, do you do a monthly self-testicular exam? ❒Yes ❒No

Do you practice “safe sex”? ❒Yes ❒No

Have you used illegal drugs? ❒Yes ❒ No

How would you describe your dietary intake? _____
_____

How many cups of coffee or caffeinated drinks do you drink daily? _____

What (if any) physical activity/exercise do you engage in and how often?_____
_____
_____

Do you smoke? ❒ Now ❒Past ❒Never
If so, how many per day and for how long? _____

How much alcohol do you drink? _____ per day _____per week
If yes, how many times in the past month have you had more than 4 alcoholic drinks in one day?
_____

Are you currently experiencing any of the following? Please circle all that apply:

Loss of interest in things you used to enjoy
Chronic sadness
Problems concentrating/decision making
Restlessness, inability to sit still
Hopelessness
Thought of death/suicide
Feelings of worthlessness, guit
Loss of energy/exhaustion
Changes in appetite
Other: please list_____

FOR FEMALES ONLY

First Day of Last Menstrual Period:_____/_____/_____

Length of period_____days; typical interval between periods_____days

Form of Birth Control:_____

Date of last Pap Smear: _____/_____/_____ Provider Name:_____

Date of last Mammogram: _____/_____/_____ Benign Exam? ❒Yes or ❒No

Menopause? ❒Yes or ❒No

Recent Pregnancy? ❒Yes or ❒No; Miscarriages? ❒Yes or ❒No;

Live births? ❒Yes or ❒No; Terminations? ❒Yes or ❒No