

Commonwealth Primary Care, Inc. Patient History

Today's Date: _____

Physician/Location: Glen Forest Ridgefield Three Chopt Huguenot RPC Wyndham
 Sommerville VFP Commonwealth Extended Care

Patient Name: _____ Date of Birth: _____

Sex: Male Female Phone Number: (home) _____ (work) _____ (mobile) _____

Best number to reach you? _____

Past Medical History

Check any illnesses or conditions you have had:

- | | | | | |
|--|-------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice/Liver Problems | <input type="checkbox"/> STD's | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Substance Abuse | _____ |

Past Surgical History

Check any past surgeries you have had:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Coronary Stent | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Wisdom Teeth |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Lap band | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Orthopedic | _____ |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) | | | |

Date of Last **Colonoscopy**: ___/___/___ Date of Last **DEXA**: ___/___/___ Date of Last **Eye Exam**: ___/___/___

Please list current **MEDICATIONS** with dosing (including nonprescription meds, vitamins, and supplements):

Please list any **ALLERGIES** to medications, latex, or any other substances:

Family History

Check illnesses which have occurred in any of your BLOOD RELATIVES:

	Family Member	Type	Family Member
<input type="checkbox"/> Allergy	_____	_____	<input type="checkbox"/> Bleeding tendency _____
<input type="checkbox"/> Cancer	_____	_____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Heart disease	_____	_____	<input type="checkbox"/> High blood pressure _____
<input type="checkbox"/> Kidney disease	_____	_____	<input type="checkbox"/> Nervous illness _____
<input type="checkbox"/> Tuberculosis	_____	_____	<input type="checkbox"/> Other _____

Commonwealth Primary Care, Inc.

Patient History

Patient Name: _____ Date: _____

Reproductive History (if applicable)

Onset of last menstrual cycle: _____ Periods are: Regular Irregular Other: _____

Number of pregnancies: _____ Number of miscarriages: _____ Current contraceptive: _____

Date of Last **Mammogram**: ___/___/___

Date of Last **Pap Smear**: ___/___/___

Social History (if applicable)

Occupation: _____ How long: _____

Marital Status: Married Divorced Single Widowed

Do you Exercise? yes no #: _____ per Day / Week / Month

Do you use: Tobacco: yes no #/day: _____ years of use _____

Alcohol: yes no #/day: _____ years of use _____

Caffeine: yes no #/day: _____ years of use _____

Illegal Drugs: yes no #/day: _____ years of use _____

Education Level: _____

Where and When have you lived or traveled outside of the U.S. or Canada: _____

Mother: Living Deceased

Father: Living Deceased

Brothers: # Living _____ # Deceased _____

Sisters: # Living _____ # Deceased _____

Do you have any children? yes no

If yes, please list date of birth, age, and gender: _____

Check the disease against which you have been immunized. Please list the most current immunization date and location.

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Pneumovax _____

Prevnar _____

Other: _____