COMMONWEALTH PRIMARY CARE, INC.

PATIENT HISTORY

Today's Date: ______________________

Patient Name: ____ Date of Birth: ______________

Phone Number: (HOME) _________________ (WORK) _________________ (MOBILE) ____________________

Best number to reach you? _______________

PAST MEDICAL HISTORY: (Check any illnesses or conditions you have had)

☐ Anemia	☐ Depression	☐ Heart Disease	☐ Nervous disorder	☐ Thyroid
☐ Anxiety	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia	☐ Tuberculosis
☐ Asthma/Bronchitis	☐ Emphysema	☐ Jaundice/Liver Problems	☐ STD's	☐ Other:__________
☐ Bleeding tendency	☐ Epilepsy	☐ Kidney problems	☐ Stroke	______________
☐ Cancer__________	☐ Glaucoma	☐ Migraines	☐ Substance Abuse	______________

PAST SURGICAL HISTORY: (Check any past surgeries you have had)

☐ Appendectomy	☐ Coronary Artery Bypass Graft (CABG)	☐ Hysterectomy	☐ Tonsillectomy
☐ Carotid Endarterectomy	☐ Coronary Stent	☐ Kidney Surgery	☐ Wisdom Teeth
☐ Cholecystectomy	☐ C-Section	☐ Lap band	☐ Other: ______________
☐ Colon Surgery	☐ Gastric Bypass	☐ Orthopedic	______________

Date of Last **Colonoscopy**: __________ Date of Last **DEXA**: _________ Date of Last **Eye Exam**: ____________

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

____

____

____

____

ALLERGIES: (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
☐ Allergy	______________	____________	☐ Bleeding tendency	______________
☐ Cancer	______________	____________	☐ Diabetes	______________
☐ Heart disease	______________		☐ High Blood Pressure	______________
☐ Kidney disease	______________		☐ Nervous Illness	______________
☐ Tuberculosis	______________		☐ Other	______________

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PATIENT HISTORY

Patient Name: ____ Date of Birth: ____________

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 TIMES #:__________ 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: ______________________________________

____

IMMUNIZATIONS:

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: ________________________

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