PROVIDENCE Medical Group

PROVIDENCE MEDICAL GROUP –Lloyd

Welcome to the clinic. Please use this form to help us understand your medical history

Full Name: _____ DOB: _____
Reason for visit today: _____
Recent Medical Providers: _____

PERSONAL HEALTH HISTORY: *Circle if you have been diagnosed with any of these conditions.*

Anemia	Depression	Meningitis
Anesthesia Complications	Diabetes	Myocardial Infraction
Anxiety	Emphysema	Nerve/Muscle Disease
Arthritis	Environmental Allergies	Osteoporosis
Asthma	Gerd	Seizures
Blood Transfusion	Glaucoma	Sickle Cell Anemia
Cancer	Heart Murmur	Stroke
Cataracts	HIV/AIDS	Substance Abuse
Congestive Heart Failure	Hyperlipidemia	Thyroid Disease
Clotting Disorder	Hypertension	Tuberculosis
COPD	Kidney Disease	

Other: _____

Health Screenings (please indicate date of last check):
Colon screening: _____Bone Density: _____TB Test: _____
Fasting Labs: _____ HIV test: _____ Hepatitis C: _____ PSA: _____

SURGICAL HISTORY: *Please list any surgeries, hospitalizations, and the date and location.*

Surgery or Reason for Hospitalization	Approximate Date	Location

CURRENT MEDICATIONS: *Please include herbals, supplements, and over the counter medications.*

Medication	Dose	Frequency	Reason for Taking	When Started

ALLERGIES: *Please list all Medication allergies, and the reaction, if known*

Medication	Reaction		Medication	Reaction

FAMILY HEALTH HISTORY: *Please list any known health problems in the following family members:*

	Alive	Age(s)	Deceased	Medical Problems
Mother				
Father				
Sister(s)				
Brother(s)				

Females Only:
Date of Last Menstrual Period: _____ or Menopausal at age _____
Birth Control Method: _____
# of pregnancies: _____ # of deliveries: _____ # of miscarriages: _____ # of abortions: _____
Last Mammogram: _____ Ever had an abnormal mammogram? Yes No If yes, date: _____
Last Pap smear: _____ Ever had an abnormal Pap? Yes No If yes, date: _____

SOCIAL HISTORY:
Occupation: _____
Where were you born and raised? _____
Marital Status: (circle one) Single Married Divorced Cohabitating
Children? (Names, ages): _____
Others living with you? _____
Sexually active? *Please circle* Y/N If yes, are you sexually active with men, women or both?

MOOD	0=Not at all	1= Several days	2=More than half the days	3=Nearly every day
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○	○	○

HABITS:
Regular Exercise? Yes ___ No ___ How often? _____ times per week. Type: _____
Do you smoke? _____ If yes, age you started smoking? _____ Year you quit? _____Packs per day? ____

Are you currently in recovery for alcohol or substance abuse? YES O NO O

Alcohol: One drink = 

12 oz. Beer  5 oz. Wine  1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?	O	O
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	O	O

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or More
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	O	O