allcare
Medical Group

Health History

Patient Name: _____ Date of Birth: _____

Who was your last primary care provider? _____

Please list other Health Care Providers or Specialists you are currently seeing as a patient:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING

- ☐ Anemia
- ☐ Angina/Heart Attack
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots | Location: _____
- ☐ Bipolar Disorder
- ☐ Blind/Vision Issues
- ☐ Cancer | Type: _____
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Deaf/Hearing Issues
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Esophageal/GERD
- ☐ Excessive Snoring/Sleep Apnea
- ☐ Fibromyalgia
- ☐ Heart Failure
- ☐ Heart Valve Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Painful Menses
- ☐ Prostate Enlargement
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Vascular Disease
- ☐ Migraine

MEDICATIONS

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Medications *(please list all)*	Dose *(Mg., pill, etc.)* and Frequency *(once daily, twice, etc.)*

ALLERGIES

Allergies *(environmental, food, drug)*	Reaction *(symptoms)*

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Health History *(continued)*

FAMILY HISTORY

Father (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Mother (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Children How Many: _____ Age: _____ Health: _____

LIFESTYLE

Occupation: _____

Married Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

Caffeine: How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Are you or others concerned about your drinking? ☐ Yes ☐ No

Tobacco and Vape Use

Do you currently use any forms of tobacco or do you vape? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? ☐ Yes ☐ No

Drug Use

Do you have a history of Drug use? ☐ Yes ☐ No (if yes, what substance) _____

Do you have problems with walking or balance? ☐ Yes ☐ No

PREVIOUS SURGERIES (if additional surgeries attach an additional sheet of paper)

	Type	**Year**
1		
2		
3		
4		

Date of Last Colonoscopy: _____ Date of Last Bone Density: _____

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

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Health History *(continued)*

Men Only

Date of last PSA test: _____

Diabetic Patients

Date of last foot exam: _____ Date of last eye exam: _____

Date of last A1c: _____ Date of last cholesterol panel: _____

LIFESTYLE

Exercise/Activity

What Type of Exercise do you do (example: walking, swimming, running)? _____

How long? _____ How often? _____

Falls

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the Medical Assistant). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Hepatitis C Testing

Have you ever been tested for Hepatitis C? ☐ Yes ☐ No

The United States Preventative taskforce recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years at least once in a lifetime.