Clark Physician Group

A Norton and LifePoint Partnership

Date: ______________________________

FAMILY AND PERSONAL HEALTH HISTORY

Patient's Full Name: ____ DOB: _______________________

Pharmacy Name/Address: ____

Previous Primary Care Physician: __________________________ Referred by: ______________________________

Have you been seen in our office before: Yes No

OTHER PHYSICIANS THAT PARTICIPATE IN YOUR HEALTHCARE:

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

MEDICATION/SUBSTANCE ALLERGIES: (Please list reactions)

1. ____
2. ____
3. ____

MEDICATIONS: (Please list name, dose, and frequency)

1. ____ 6. ____
2. ____ 7. ____
3. ____ 8. ____
4. ____ 9. ____
5. ____ 10. ____

ADVANCED DIRECTIVES:

Do you have a Living Will? (Please provide copy) [ ] Yes [ ] No

Do you have a Power of Attorney? (Please provide copy) [ ] Yes [ ] No

What is your Code Status? (Example: DNR- Do Not Resuscitate) _____________

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Alcohol Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _________

Tobacco Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _________

Illicit Drug Use: [ ] None [ ] Marijuana [ ] Cocaine [ ] Crack [ ] Meth [ ] Other ___________

Caffeine Use: [ ] Soda [ ] Coffee [ ] Tea # per day_________

Do you exercise regularly: [ ] Yes [ ] No How many times per week? _____ How long? _____

Activities:____

Religion: ____

Occupation:____

With whom do you live?____

Patient's Name: ______________________________

DOB: ______________________________

PERSONAL HISTORY:

[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Heart Attack
[ ] Yes [ ] No Heart Disease
[ ] Yes [ ] No High Blood Pressure
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Depression, Anxiety, Bi-Polar
[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Cancer (Type) ___________
[ ] Yes [ ] No Other __________________

# of Preganc ies ____ # of Live Births ____ Miscarriages ____ Abortions ____

C-Sections (# and Year) ______________________

PREVENTIVE HEALTH: (Please list dates and results)

Cholesterol ______________________________
Mammogram ______________________________
Colonoscopy ______________________________
Dexa Scan ______________________________
Pap Smear ______________________________
PSA ______________________________

IMMUNIZATIONS: (Please list dates)

Pneumonia ______________________________
Tetanus ______________________________
Measles ______________________________
Influenza ______________________________
Other ______________________________
Hepatitis A ______________________________
Hepatitis B ______________________________
Tuberculosis ______________________________
Shingles ______________________________
Other ______________________________

FAMILY HISTORY: (Please check all that apply)

Illness/Condition	Father	Mother	Sibling	Grandparents (Maternal/Paternal)
Diabetes				
Heart Attack				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Disease				
Depression/Anxiety/Bi-Polar				
Stroke				
Osteoporosis				
Cancer				
Other				

RECENT HOSPITALIZATIONS: (Year, Illness, Surgeries)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________