WELLSTAR
Physicians Group

PATIENT HISTORY FORM

PERSONAL INFORMATION:

Name:_____ Date:_____

Date of Birth: _____ Age:_____ Sex: ___M ___F

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Remarried

Occupation: _____

Spouse Name: _____ Spouse's Occupation: _____

List people in your household, relationship and year of birth:

_____ _____ _____

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES/ADVERSE DRUG REACTIONS/OTHER ALLERGIES:

_____ _____ _____

_____ _____ _____

CURRENT MEDICAL HISTORY:

How do you rate your present health status? ___Excellent ___ Good ___ Fair ___Poor

What do you regard as your **main** medical problem(s)? _____

_____

Please list all prescriptions or over-the-counter medications with dose and frequency taken including vitamins and herbs:
Example: Motrin 400mg 3times a day:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any other source of health care (physician clinic, urgent care, laboratory, radiology, therapist, chiropractor, etc...)

Date	Provider or Site	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patients Initials: _____ Provider Initials:_____

WELLSTAR Physicians Group

Patient Name:_____
Birth Date:_____

PERSONAL HABITS	YES	NO	PREVIOUS		
Do you wear seatbelts?	☐	☐	☐		
Do you exercise regularly?	☐	☐	☐	_____ times/wk	Type:_____
Do you smoke?	☐	☐	☐	_____ packs/day	Number of years:_____
Do you chew tobacco?	☐	☐	☐	_____ packs/day	Number of years:_____
Do you drink alcohol?	☐	☐	☐	_____ drinks/day	Number of years:_____
Do you drink caffeine?	☐	☐	☐	_____ drinks/day	Number of years:_____
Do you experience difficulty with drugs, alcohol or other substances?	☐	☐	☐	If *Yes, specify*:	_____

Have you ever had:	YES	NO	Any additional information:
Blood Transfusion	☐	☐	_____
I.V. Drug Use	☐	☐	_____
Unsafe Sex	☐	☐	_____
Sexually Transmitted Disease	☐	☐	_____

PAST MEDICAL HISTORY:

1. Indicate any operations you have had and the year performed:

_____

_____

2. Indicate all hospitalizations you have had for non-surgical illnesses and give the year hospitalized if possible:

_____

_____

3. Indicate any major adult or childhood illnesses with the year of the illness:

_____

_____

4. If you have had any of the following, please check and indicate date if possible:

	Date		Date		Date / Results
Physical Exams	_____	Dental Exam	_____	EKG	_____/_____
Tetanus shot	_____	Eye Exam	_____	Stress Test	_____/_____
Flu shot	_____	Rectal Exam	_____	Blood Pressure	_____/_____
PSA	_____	Pneumonia shot	_____	Cholesterol	_____/_____
Rubella Shot	_____	Hepatitis Shot	_____	Sigmoidoscopy	_____/_____

Patients Initials: _____ Provider Initials:_____