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: __________

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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: ______

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Patient Name:____________________
Birth Date:____________________

FAMILY HISTORY: Please give approximate date of onset of each disease, if known:

	Father	Mother	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐
Year of Birth						
Year of Death						
Cause of Death						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Anemia						
Stroke						
Diabetes						
Cancer (type)						
Kidney Disease						
Asthma						
Tuberculosis						
Migraines						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Other:						
Other:						

FOR WOMEN ONLY:

Date of last menstrual period: ____________________

Difficulty with periods? ____Y ____N

Describe:____________________________________

Changes in menstrual pattern? ____Y ____N

Describe: ____________________________________

When was your last Pap Smear? ________________

Number of pregnancies:________________________

Number of live births: ________________________

If menopausal, date of onset:___________________

Date of last mammogram:_______________________

Do you practice breast self exam? _______Y _____N

What is your method of birth control? ____________

FOR MEN ONLY:

Do you practice testicular self-exams? _____Y _____N Need Instruction:_______________

Have you ever had a Prostate Screening Test? _____Y ____N Date: ________________

What method of birth control do you use?____

Patients Initials: ___________

Provider Initials:__________

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PLEASE CHECK ANY RECENT OR RECURRING PROBLEMS YOU HAVE EXPERIENCED:

____Abdominal Pain	____Difficulty Swallowing	____Heartburn
____Back Pain	____Joint Pain	____Chest Pain
____Rapid Heart Rate	____Wheezing	____Cough
____Fever	____Swollen Glands	____Shortness of Breath
____Skin Rash	____Swelling of Extremities	____Difficulty Sleeping
____Depression	____Anxiety	____Reaction to Anesthesia
____Lack of Energy	____Constipation	____Nausea
____Hay Fever	____Nasal Congestion	____Headaches
____Problem Hearing	____Vision Problems	____Dizziness
____Fainting	____Abnormal Vaginal Bleeding	____ Rectal Bleeding
____Bleeding	____Pelvic Pain	____Hot Flashes
____Vaginal Discharge	____Poor Appetite	____Burning w/Urination
____Weight Gain	____Weight Loss	____Diarrhea
____Chills	____Unsafe work conditions	____Sexual Difficulties
____Violence at home	____Hazardous work or hobbies	

COMMUNICATION NEEDS:

Language if other than English: ____

Vision: _____ Normal _____Glasses _____Contacts _____Blind

Hearing: _____ Normal _____ Hard of Hearing _____ Hearing Aid _____ Deaf

Interpreter Needed: _____ Y _____ N

Did someone else fill out this form? _____Y _____N Who?______________________________

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for you? ___Y ____N
*If YES, explain:*____

ADVANCE DIRECTIVES:

Do you have an Advance Directive: ____Y ____N

If YES, do you have:

Living Will	____Y ____N
Durable Power of Attorney for Healthcare	____Y ____N
Directive for Final Healthcare	____Y ____N

Who would you want to make decisions for you in the event you are unable to make them for yourself?______________________

____

If you have an Advance Directive, please bring us a copy for your chart.

Patient Signature______________________________________ Date__________________

Provider Signature:_____________________________________ Date:_________________