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:_____