South Community Primary Care

Initial Health History Form

Patient Name:_____ Date of Birth:_____

Patient Past Medical History

YES	NO	
		High Blood Pressure
		High Cholesterol
		Heart Disease
		Heart Murmur
		Diabetes Type 1 Type 2
		Thyroid Disease
		Seizures
		COPD
		Asthma
		GERD (Acid Reflux)
		Kidney Problems
		Colon Problems
		Sexually Transmitted Disease
		Anxiety
		Depression
		Abnormal PAP
		ADHD
		Alcohol Abuse
		Sickle Cell Anemia
		Recurrent Urinary Infections
		(Other)

Family Medical History

Maternal (Mother) Side	Paternal (Father) Side	
		Alcoholism
		Asthma
		Cancer:
		Depression
		Diabetes: Type 1 Type 2
		Heart Disease
		High Cholesterol
		High Blood Pressure
		Thyroid Disease
		Inherited Genetic Disorder
		Sickle Cell Disease
		ADD/ ADHD
		Mental Health Issues
		Substance Abuse
		(Other)

_____# Pregnancies _____# Children

Previous Primary Care Dr _____
Last Colonoscopy _____Facility_____
Specialists _____
_____

Last Mammogram _____
Last PAP _____

Last ER Visit _____ **Facility**_____
Hospitalizations _____ **Facility** _____
Dentist _____
Eye Dr _____

Surgical History

YES	NO		DATE
		Appendectomy (Appendix)	
		Back Surgery	
		Cholecystectomy (Gall Bladder)	
		Hernia Repair	
		Hysterectomy	
		Tonsillectomy (Removal of Tonsils)	
		Tubal Ligation	
		Adenoidectomy (Removal of Adenoids)	
		(Other)	

(SEE OTHER SIDE)

Social History

YES	NO	
		Current Everyday Smoker _____#PPD
		Former Smoker
		Never Smoked
		Passive Smoker
		Alcohol Use (How often?)
		Past Drug Use (Please specify)
		Current Drug Use (Please specify)
		Exercise
		Follows a Diet
		Caffeine (How often?)
		Employed
		Abuse History _____Emotional _____Physical _____Sexual
		Sexually Active Use of Birth Control? YES NO
		Child Living with Guardian/Caregiver? (Please specify)

Current Medications

MEDICATION	DOSAGE	INSTRUCTIONS