HealthVisionsMD, Inc.
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PATIENT HISTORY

Name: _____ Today's Date: _____
DOB: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe the recent event(s) that resulted in today's visit: _____

_____

MEDICAL HISTORY

1. Name of any physician(s) involved in your care:

Name	Specialty	First Visit Date	Last Visit Date

2. Do you take medications, including vitamins, herbal and natural supplements, and prescribed medications: ☐ Yes ☐ No

Name	Dosage	Frequency	Date Started

3. Do you have medication allergies: ☐ Yes ☐ No If yes, please specify the medication(s) and reaction(s): _____

_____

4. Which pharmacy do you use for prescription medications?

Name	Location	Telephone	Fax

5. Check any of the following problems that apply to you:

☐ Arthritis	☐ Dementia/Alzheimer	☐ Heart disease	☐ Stroke
☐ Asthma	☐ Depression	☐ Heart attack	☐ Thyroid disease
☐ Bowel Problems	☐ Diabetes	☐ High blood pressure	☐ Ulcers
☐ Bronchitis	☐ Emphysema	☐ Joint or Bone Issues	☐ Urinary problems
☐ Cancer	☐ Eye problems	☐ Kidney disease/stones	☐ Other, please list below

_____

6. List any surgeries or hospital stays you have had, in the past. Please provide pertinent details.

Date	Type of Surgery / Reason for Hospitalization	Physician

7. If you have any other medical problems or serious injuries that are not listed above, please describe them here: _____

_____

8. Have you had an annual physical? ☐ Yes ☐ No When was your last physical? _____/_____/_____

Date: _____
Height: _____
Weight: _____

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Name: _____
DOB: _____
MR#: _____

9. Please note the dates of your most recent immunizations:

☐ Hepatitis A _____ ☐ Tetanus _____ ☐ Pneumonia _____ ☐ Other, please list below
☐ Hepatitis B _____ ☐ Influenza (Flu) _____ ☐ Shingles _____ ☐ Travel vaccinations

10. Please note the dates of your most recent test, if performed, and the results, if known:

☐ Bone Density Scan _____ ☐ Cholesterol _____ ☐ Colonoscopy _____
Results: _____ Results: _____ Results: _____
☐ Mammogram _____ ☐ Pap smear _____ ☐ Prostate exam _____
Results: _____ Results: _____ Results: _____

FAMILY MEDICAL HISTORY

Please list any immediate family members who have experienced the following:

Cancer & Type	☐ Yes ☐ No	Family Member?	_____
Heart Disease	☐ Yes ☐ No	Family Member?	_____
High Blood Pressure	☐ Yes ☐ No	Family Member?	_____
Stroke	☐ Yes ☐ No	Family Member?	_____
Diabetes	☐ Yes ☐ No	Family Member?	_____
Mental Illness	☐ Yes ☐ No	Family Member?	_____
Drug/Alcohol Abuse	☐ Yes ☐ No	Family Member?	_____
Any other illness	☐ Yes ☐ No	Family Member?	_____

SOCIAL HISTORY

Race _____ Ethnicity _____ Do you have an end of life directive? ☐ No ☐ Yes ☐ Living Will ☐ Power of Attorney

Marital Status: ☐ Single ☐ Separated ☐ Divorce ☐ Widowed
☐ Married/Partnered Spouse/Partner Name: _____

Living Situation: ☐ Live alone ☐ Live with spouse/partner ☐ Live with other _____

Employment: ☐ Occupation / Employer _____
☐ Homemaker ☐ Student (where/major/year) _____

Tobacco Use: ☐ No, I do not smoke and never have smoked
☐ Yes, I previously smoked; no longer smoke. Quit date: _____/_____/____ Number of packs/day _____
☐ Yes, I currently smoke. Years smoking: _____ Number of packs/day _____

Alcohol Use: ☐ No, I do not drink any alcohol
☐ Yes, I previously drank; no longer drink alcohol. Quit date: _____/_____/____ Number of drinks/day _____
☐ Yes, I currently drink. Years drinking: _____ Number of drinks/day _____

Drugs: Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No
What type of street drugs have you used in the past or are currently using? _____

Sexual Behavior: Are you sexually active? ☐ Yes ☐ No If yes, are you currently trying to become pregnant? ☐ Yes ☐ No
If not trying to become pregnant, list contraceptive or barrier method using: _____
When was your last menstrual period? _____ How many periods do you have per year? _____

Military Service: Have you ever been in military service? ☐ Yes ☐ No If so, which branch? _____