[Patient Label]

PROVIDENCE Multi-Service Clinic Lacey

Adult Medical History *Date:* _____/_____/_____

Please take a few minutes to fill out this History introduction. The information will help us provide better care.

Name:_____ Age: _____ Birthdate:_____/_____/_____

Occupation_____ Sex: ☐ Male ☐ Female

Home Phone: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name: _____

Children's names and ages: _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medication and type of reaction)

_____ _____ _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc)

Please bring ALL medications with you to your first appointment. If additional room is needed, please list on a separate page

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History and Review of Systems

Please circle if you have had problems with, or are currently experiencing, any of the following:

Anemia	CHF	Glaucoma	Nerve/Muscle Disease
Anesthesia Complications	Clotting Disorder	Heart Murmur	Osteoporosis
Anxiety	COPD	HIV/AIDS	Seizures
Arthritis	Depression	Hyperlipidemia	Sickle Cell Anemia
Asthma	Diabetes Mellitus	Hypertension	Stroke
Blood Transfusion	Emphysema	Kidney Disease	Substance Abuse
Cancer	Environmental Allergies	Meningitis	Thyroid Disease
Cataracts	GERD	Myocardial Infarction	Tuberculosis
OTHER: _____	_____	_____	_____

Past Surgical History:

Appendectomy	☐ Yes ☐ No	Colon Surgery	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Brain Surgery	☐ Yes ☐ No	Cosmetic Surgery	☐ Yes ☐ No	Small Intestine Surgery	☐ Yes ☐ No
Breast Surgery	☐ Yes ☐ No	Eye Surgery	☐ Yes ☐ No	Spine Surgery	☐ Yes ☐ No
C-Section	☐ Yes ☐ No	Fracture Surgery	☐ Yes ☐ No	Tonsillectomy	☐ Yes ☐ No
CABG	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No	Tubal Ligation	☐ Yes ☐ No
Cholecystectomy	☐ Yes ☐ No	Hysterectomy	☐ Yes ☐ No	Valve Replacement	☐ Yes ☐ No

Other: _____

Prior Medical Care

Please list any other providers who are currently involved in your care

_____

_____

Who was your previous primary care provider? _____

[Patient Label]

PROVIDENCE
Multi-Service Clinic
Lacey

Immunizations & Procedures:

Immunization history – have you had:

Pneumovax immunization?	☐ No ☐ Yes When?_____	Hepatitis B?	☐ No ☐ Yes When?_____
Tetanus immunization?	☐ No ☐ Yes When?_____	Other?	☐ No ☐ Yes When?_____
		Flu immunization?	☐ No ☐ Yes When?_____

When was your last:

Pap smear? _____	Where? _____	Cholesterol check? _____
Mammogram? _____	Where? _____	Stool check for blood? _____
Breast exam? _____	Where? _____	Prostate exam? _____
Colonoscopy? _____	Where? _____	

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family member(s)?	Illness	Which family member(s)?
Arthritis	_____	Premature CHD	_____
Asthma	_____	High Blood Pressure	_____
Autism	_____	High Cholesterol	_____
Birth Defects	_____	Kidney Disease	_____
Cancer	_____	Learning Disabilities	_____
COPD	_____	Mental Illness	_____
Depression	_____	Developmental Delay	_____
Diabetes	_____	Miscarriages	_____
Early Death	_____	Stroke	_____
Hearing Loss	_____	Substance Abuse	_____
Heart Disease	_____	Vision Loss	

Other: _____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding:	☐ No	☐ Yes	(Please describe): _____
Leakage of urine:	☐ No	☐ Yes	(Please describe): _____
Pelvic pain:	☐ No	☐ Yes	(Please describe): _____
Abnormal discharge:	☐ No	☐ Yes	(Please describe): _____
History of abnormal pap smear:	☐ No	☐ Yes	(Please describe): _____

Social History

Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Are you sexually active?	☐ No	☐ Yes	☐ Not Currently
If yes, what gender are your partners?	☐ Male	☐ Female	☐ Both
Do you use birth control?	☐ No	☐ Yes	If yes, what kind? _____
Do you use recreational drugs?	☐ No	☐ Yes	If yes, how often? _____

If yes, circle which types: Anti-anxiety meds Amphetamines Barbituates Cocaine Heroin Inhalants LSD Marijuana Methamphetamines Nitrous Oxide Narcotics PCP IV

Other: _____

Do you use tobacco products?	☐ Never	☐ Yes	☐ Quit
		Packs per day:_____	Quit Date:_____
		Years: _____	Years: _____
Do you use smokeless tobacco?	☐ Never	☐ Yes	☐ Quit
		Packs per day:_____	Quit Date:_____
		Years: _____	Years: _____

Are you ready to discuss quitting smoking? ☐ No ☐ Yes