

## **Providence Family Medicine Center**

Legal name:	Last	First	Middle	Ethnicity:				
Preferred name:								
<b>Pronoun:</b> (i.e. she, he, they,	, name, etc.)							
Date of Birth: Month				1				
Home phone	Cell phone		Work phone	Best number to use:				
<u> </u>	( -	-	( ) -	□ Home				
		***		□ Cell				
Ok to leave voicemail?	Ok to leave voic	email?	Ok to leave voicemail?	□ Work				
Yes No <b>Emergency contact:</b>	Yes No Name	Phor	Yes No ne Relationsl	hip to you				
,								
If you are under 18: Parent/Guardian:	Name	Phone	e Relationshi	ip to you				
PERSONAL HEALTH H	ΠSTORY: Circle	if you have l	heen diaonosed with any	of these conditions				
			-	of these conditions.				
Anemia	Depression		Meningitis Diebotes Mysserdial Int	Constinu				
Anesthesia	Complication		Diabetes Myocardial Infraction					
Anxiety	Emphysema		Nerve/Muscle Disease					
Arthritis	Environmen	ntai	Allergies Osteoporosis					
Asthma	Gerd		Seizures					
Blood Transfusion	Glaucoma		Sickle Cell Anemia					
Cancer	Heart Murn	nur	Stroke					
Cataracts	HIV/AIDS		Substance Abuse					
Congestive Heart Failure	Hyperlipide		Thyroid Disease					
Clotting Disorder	Hypertensic		Tuberculosis					
COPD	Kidney Dis	ease						
Other:								
HEALTH SCREENINGS	<u>s:</u> (please indicate	date of last	check):					
Colon screening:	Mammog	gram:	Pap Smear:	HIV test:				
Bone Density:	TB Test:	Fa	asting Labs:	HIV test:				
Hepatitis C:P	SA:							
SURGICAL HISTORY: P	Please list any surg	geries, hospit	talizations, and the date c	and location.				
Surgery or Reason for Hospitalization		Approx	ximate Date	Location				

ERGIES: Please list all Medication allergies, and the reaction, if known   No known allergies   Reaction   Allergy   Reaction	37 11 41	ake any medicine	<b>5</b> •			
No known allergies   Reaction   Allergy   Reacti	Medication			Frequency	Reason for Tak	ing When Started
No known allergies						
No known allergies   Reaction   Allergy   Reacti						
No known allergies						
No known allergies   Allergy   Reaction   Allergy   Reaction						
Allergy Reaction Allergy Reaction  VANCE DIRECTIVE/CODE STATUS: (i.e. Living Will, Do Not Resuscitate, Power of Attorney, etc)  \  \text{None}  \text{Yes}, but not on file with this clinic  \text{Yes}, on file with this clinic  \text{SUAL ORIENTATION AND GENDER IDENTITY:}  \  \text{Vhat is your sexual orientation?}   \text{Lesbian or Gay}   \text{Straight (not lesbian or gay)}   \text{Bisexual}  \text{Something else}   \text{Don't know}    \text{Choose not to disclose}  \text{Sexual Orientation Additional Comments:}    \text{Hat is your gender identity?}      \text{Female}     \text{Male to Female}      \text{Transgender Male}   \text{Female to Male}     \text{Other}    \text{Choose not to disclose}   \q						
No known allergies   Allergy   Reaction   Allergy   Reaction	ERGIES: Please lis	t all Medication al	llergies, and th	ie reaction, if l	known	
Allergy Reaction Allergy Reaction  VANCE DIRECTIVE/CODE STATUS: (i.e. Living Will, Do Not Resuscitate, Power of Attorney, etc)  \  \text{None}  \text{Yes}, but not on file with this clinic  \text{Yes}, on file with this clinic  \text{Yes}, on file with this clinic  \text{Yes}, on file with this clinic  \text{VAL ORIENTATION AND GENDER IDENTITY:}  \  \text{Vhat is your sexual orientation?}   \text{Lesbian or Gay}   \text{Straight} (not lesbian or gay)   \text{Bisexual}  \text{Something else}  \text{Don't know}    \text{Choose not to disclose}  \text{Sexual Orientation Additional Comments:}    \text{Hat is your gender identity?}     \text{Pemale}      \text{Male to Female}  \qu						
None			eaction		Allergy	Reaction
None						
None						
None		<u> </u>				
What is your gender identity?  □ Female □ Male □ Transgender Female / Male to Female □ Transgender Male / Female to Male □ Other □ Choose not to disclose Gender Identity Additional Comments: □ What was your sex assigned at birth? □ Female □ Male □ Unknown / Uncertain □ Not Recorded on birth certificate □ Choose not to di  ### HEALTH HISTORY: Please list any known health problems in the following family members:    Alive   Age(s)   Deceased   Medical Problems   Mother   Mothe	What is your sexual o	orientation?  ay   Straight (not leadisclose)	lesbian or gay)	) □ Bisexual	J	
What was your sex assigned at birth?  ☐ Female ☐ Male ☐ Unknown / Uncertain ☐ Not Recorded on birth certificate ☐ Choose not to di  ☐ HEALTH HISTORY: Please list any known health problems in the following family members:  ☐ Alive Age(s) Deceased Medical Problems  ☐ Mother ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		m ruditional Con	······································			
Mother	Sexual Orientation  What is your gender  □ Female □ M  □ Other □ C	ridentity?  Male □ Transgende  thoose not to disclo	er Female / Ma	ale to Female	☐ Transgender Male	
Mother	Sexual Orientation  What is your gender  Female M  Other C  Gender Identity  What was your sex a	ridentity?  Male □ Transgender  The Hoose not to disclor  Additional Communications  Additional Additional Communications  Assigned at birth?	er Female / Ma ose nents:	ale to Female	□ Transgender Male	
	Sexual Orientation  What is your gender  Female M  Other C  Gender Identity  What was your sex a  Female M	ridentity?  Male □ Transgender  The Hoose not to disclor  Additional Communication  Additional Communication  The Hoose not to disclor  Additional Communication  The Hoose not to disclor  The Hoose not to disclore  The Hoose not to disclore	er Female / Ma ose nents: /Uncertain □ N	ale to Female  Not Recorded o	☐ Transgender Male	Choose not to disclose
	Sexual Orientation  What is your gender  Female M  Other C  Gender Identity  What was your sex a  Female M	ridentity?  Male □ Transgender  hoose not to disclor  Additional Communication  assigned at birth?  Male □ Unknown /  Market □ Unknown /  Market □ Velease list	er Female / Ma  ose nents:  /Uncertain □ N  st any known h	ale to Female  Not Recorded of the alth problem	☐ Transgender Male  on birth certificate ☐  as in the following fan	Choose not to disclose
Father	Sexual Orientation  What is your gender  Female M  Other C  Gender Identity  What was your sex a  Female M  MILY HEALTH HIS	ridentity?  Male □ Transgender  hoose not to disclor  Additional Communication  assigned at birth?  Male □ Unknown /  Market □ Unknown /  Market □ Velease list	er Female / Ma  ose nents:  /Uncertain □ N  st any known h	ale to Female  Not Recorded of the alth problem	☐ Transgender Male  on birth certificate ☐  as in the following fan	Choose not to disclose

Sister(s)

Brother(s)

<u>CURRENT MEDICATIONS</u>: Please include herbals, supplements, and over the counter medications.

## **OBSTETRICS AND GYNECOLOGY HISTORY:**

Age Menstruation (period) started:				
Last Pap smear date:				
Have you had an Abnormal PAP Smear? Yes/No WI	nen?			
Are you currently pregnant? Yes/No Last Menstru	al Period:			
Have you ever been pregnant? Yes/No				
Total number of times pregnant:	To	otal number of l	ive births:	
# Miscarriages: # Abortions # Ectopic P	regnancies:			
SOCIAL HISTORY:				
Occupation:				
Where were you born and raised?				
Marital Status: (circle one) Single Married Divorced Col	nabitating			
Children? (Names, ages):				
Others living with you?				
<b>Sexually active?</b> Please circle Y/N If yes, are you sex	ually active w	ith men, women	n or both?	
MOOD	0 = Not at all	1 = Several days	2 = More than half the days	3 = Nearly every day
During the past two weeks, have you been bothered by little interest or pleasure?	0	0	Ó	0
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	0	0	0	0
HABITS:				
Regular Exercise? Yes No How often? tin	mes per week.	Type:		-
Do you smoke? If yes, age you started smoking?	Year you	quit?Pac	cks per day?	
Smokeless (Chewing) Tobacco Use?				
Are you currently in recovery for alcohol or substance abu	ise? YES 🗌	NO 🗌		
Alcohol: One drink = 12 oz. Beer	5 oz. Wine	1.5 oz. liquor (one shot)		
MEN: How many times in the past year have you had 5 or WOMEN: How many times in the past year have you had	n a day?	None 1 or Mo O O O O	ore	
Drugs: Recreational drugs include methamphetamines (sp (paint thinner, aerosol, glue), tranquilizers (Valium), barbi mushrooms), or narcotics (heroin)		ne, ecstasy, hall	ucinogens (LSD	,
How many times in the past year have you used a recreation		None 1 or M O O	ore	
How many times in the past year have you used a recreation prescription medication for nonmedical reasons?	mai urug or us	seu a	0 0	