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PROVIDENCE Medical Group

Name: ___________________________________ Date of Birth: ______________

Your health is important to us. Thank you for filling out this PRE-visit form so together we can provide the highest quality healthcare and best experience for you.

What is the **most important** issue for us to address at today's visit?

____

Medications, Vitamins and Supplements:

Please list the name, strength, and frequency of the medication.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Drug and Food Allergies:

Please list the allergy and type of reaction. If no allergies, check ☐ and skip this section.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

PERSONAL MEDICAL HISTORY

Do you have or have you had in the past any of the following conditions?

- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cataracts
- ☐ Heart Failure (CHF)
- ☐ Blood Clot
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Environmental Allergies
- ☐ Acid Reflux (GERD)
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Meningitis
- ☐ Heart Attack
- ☐ Nerve / Muscle Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other ______________

SURGICAL HISTORY

List all surgeries and serious illnesses:	Year	Hospital/Location
______________________________	__________	______________________
______________________________	__________	______________________
______________________________	__________	______________________

FAMILY HISTORY

If adopted or unknown check here ☐

Relationship	Name (optional)	Alive	No Known Problems	Arthritis	Breast Cancer	Colon Cancer	Cancer - Other	Clotting Disorder	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Lung Disease	Mental Illness	Stroke	Substance Abuse	Other
Mother		Y N																	
Father		Y N																	
Sister(s)		Y N																	
Brother(s)		Y N																	
Daughter(s)		Y N																	
Son(s)		Y N																	
Mom's Sister(s)		Y N																	
Mom's Brother(s)		Y N																	
Dad's Sister(s)		Y N																	
Dad's Brother(s)		Y N																	
Mom's Mom		Y N																	
Mom's Dad		Y N																	
Dad's Mom		Y N																	
Dad's Dad		Y N																	

As best you can, mark which relative has had these diseases. The health of your parents, brothers, and sisters is most important.

SOCIAL HISTORY

Marital Status (if applicable): ___________ Occupation: __________________ Hobbies: _________________

Are you sexually active? ☐ Yes ☐ No If yes, partners: ☐ Male ☐ Female

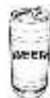
Do you use **tobacco** products? ☐ Yes ☐ No ☐ Quit Date: _______ ☐ Never used tobacco

If Yes: How many packs/cans per day?_____ How many years?____ Are you interested in quitting? ☐ Yes ☐ No

How many times a week do you exercise? _______ What type of exercise do you do? ___________________________

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =



12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:

	Not at all	Several days	More than half of the days	Nearly every day
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○	○	○

Food:

	Yes	No
Within the past 12 months, we worried whether our food would run out.	○	○
Within the past 12 months, the food we bought just didn't last.	○	○

PREVENTIVE HEALTH

For **women only:**

1. Last menstrual period - Date: ________________
2. Are you currently breast feeding? ☐ Yes ☐ No
3. If sexually active with men:
   - Would you like to become pregnant in the next year? ☐ Yes ☐ No
   - Are you using contraception? ☐ Yes ☐ No

☐ Oral Birth Control	☐ Ring / Patch	☐ Hysterectomy	☐ Condoms
☐ IUD	☐ Nexplanon Implant	☐ Post-Menopause	☐ Sponge / Spermicide
☐ Depo Provera	☐ Tubal Ligation	☐ Vasectomy	☐ Other ______________
Effective Reversible Contraception		*Other Contraception*	

Date of last pap: __________ Location: __________ Date of last mammogram: __________ Location: __________

Have you had a **Colonoscopy** in the past 10 years? ☐ Yes: Date ___________ Location:________________ ☐ No

Other Preventive Health Care: *Approximate dates, if known.*

Flu Vaccine: _________________ Tetanus Vaccine: _____________ Cholesterol Blood Test: ________
Pneumonia Vaccine: __________ Shingles Vaccine: _____________ Diabetes Screening Test: ______

GENERAL:

Do you have a Healthcare Representative or Power of Attorney? ☐ No

Name: ____________________________ Phone: ______________