Progress Ridge Family Medicine

Welcome to the clinic. Please use this form to help us understand your medical history.

Full Name: ____________________________________ DOB: _______________________
Reason for visit today: ____
Recent Medical Providers: ____

Personal Health History

Please tell us if you have been diagnosed with any of these conditions. Circle "Y" for yes, "N" for no.

Seasonal Allergies	Y	N	Heartburn	Y	N
Glaucoma	Y	N	Hepatitis	Y	N
Hearing loss	Y	N	Erectile Dysfunction	Y	N
Thyroid problems	Y	N	Infertility	Y	N
Asthma	Y	N	Sexual Infection	Y	N
COPD/Emphysema	Y	N	Kidney Problems	Y	N
Tuberculosis	Y	N	Prostate Disease	Y	N
Irregular heart beat	Y	N	Sexual Dysfunction	Y	N
Heart Attack	Y	N	Diabetes	Y	N
Eating disorder	Y	N	Bleeding Disorder	Y	N
Atrial Fibrillation	Y	N	Stroke	Y	N
Heart Failure	Y	N	Mental Health	Y	N
Heart Valve Disease	Y	N	Anemia	Y	N
Bowel Problems	Y	N	Eczema/Psoriasis	Y	N

Other:____

Health Screenings (please indicate date of last check)

Colon Screening: _________ **Fasting Labs:** _________ **Bone Density:** _________
HIV Testing: _________ **TB testing:** _________ **Hepatitis C screening:** _________
PSA: _________

Surgical History

Please list any surgeries, hospitalizations and the approximate date and location:

Surgery or reason for hospitalization	Approximate Date	Location

Current Medications

Please include herbals, supplements and over the counter medications:

Medication	Dose	Frequency	Reason for taking	Start date

Females Only

Date of Last Menstrual Period:____________ or Menopausal at age:__________
Birth Control Method: ____
# of pregnancies: _____ # of deliveries: _____ # of miscarriages: ______# of abortions:______
Last Mammogram: ______Ever had an abnormal mammogram? YES NO If yes, date _____
Last Pap smear:_________ Ever had an abnormal pap smear? YES NO If yes, date _____

Allergies

Please list all Medication allergies and the reaction if known

Medication	Reaction

Family Health History

Please list any known health problems in the following family members:

Family Member	Alive	Age	Deceased	Medical Problems
Mother				
Father				
Sister				
Brother				
Other				

Social History

Occupation: ______________________ **Where were you born and raised?** ______________________

Marital Status: (circle one) Single Married Divorced Cohabitating

Children? (Names, ages) ___________________________ Others live with you? ___________________

Sexual Orientation: (circle your answer): Heterosexual Homosexual Bisexual Transgender

Other: _______________________

Habits

Regular exercise? (Circle one) Yes No How often? ____ times per week.

Type of exercise: ____

Do you smoke? (Circle one) Yes No If yes, age you started smoking? ______

Year you quit? _______ Packs per day? _______

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

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 nonmedical reasons?	○	○

Review of Systems

Please circle any of these symptoms you have experienced in the last three months:

Anxiety or depression	Palpitations	Pain with intercourse
Sore throat	Abdominal pain	Headaches
Runny nose	Heartburn	Dizziness
Hearing loss	Bowel habit changes	Weakness
Visual changes	Sexual concerns	Joint pains
Cough	Urinary changes	Skin rashes
Wheezing	Change in periods	Changing moles
Chest pain	Pelvic pain	Breast lumps or pain