Harnett Health

Medical History Information

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____
Gender: M/F

Pharmacy Name _____ Pharmacy Phone (____)_____

PAST MEDICAL HISTORY

Are you allergic to any medications? _____No _____Yes If yes, which ones?

_____ _____
_____ _____
_____ _____
_____ _____

Do you have a history of:

☐ Asthma
☐ Lung Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Failure
☐ Heart Attack
☐ Heartburn or Reflux
☐ Cancer (type _____)
☐ Degenerative Arthritis
☐ Rheumatoid Arthritis
☐ Kidney Stones
☐ Kidney Disease
☐ Disc Disease
☐ Tuberculosis
☐ Gout
☐ Intestinal Disorder
☐ Diabetes
☐ Thyroid problems
☐ Colitis
☐ Metabolic Disorder
☐ Stroke
☐ Mental Illness
☐ HIV / AIDS
☐ Other
(_____)

Date of last Physical Exam: _____
Date of Last Colonoscopy: _____
Date of Last Bone Density Test: _____

For Females:
Date of last Mammogram _____
Date of Last Breast and Pelvic Exam _____
Number of Prior Pregnancies _____
Number of Live Births: _____

For Males:
Date of Last Prostate Exam: _____

DOB and names of Children:

_____ _____
_____ _____
_____ _____

Have you had any surgeries? Please list type and approximate date:

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized? ☐ No ☐ Yes If yes, for what reason?

_____ _____
_____ _____
_____ _____
_____ _____

List prescription and over-the-counter medications you currently take:

_____ _____
_____ _____
_____ _____
_____ _____

Check the immunizations you've had. Please give the approximate date for each.

☐ Influenza (Seasonal Flu) _____ ☐ H1N1 Influenza _____
☐ Pneumonia _____ ☐ Shingles _____
☐ Chicken Pox _____ ☐ Tetanus _____
☐ HPV Vaccine(Gardasil) _____ ☐ Hepatitis B _____

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Cancer: type _____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease or Stroke	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes If yes, how much?_____
Did you ever smoke? ☐ No ☐ Yes If yes, for how many years? _____

Number of alcoholic drinks you consume per week? _____

Do you use street drugs? ☐ No ☐ Yes If yes, type _____

Gender Preference: ☐ Men ☐ Women ☐ Both

Are you: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

How often do you exercise and what activities do you do?_____
_____
_____

Do you work outside the home? ☐ No ☐ Yes: occupation _____

Do you have an end of life plan? (Living Will, Health Care Power of Attorney, Do Not Resuscitate, Do Not Intubate, Full Code). *We are happy to discuss the above as it is important for those of all ages.*

Patient Signature _____ Date: _____
(or parent if minor)

I was referred to Harnett Health by: _____