SILVER BIRCH
– MEDICAL CLINIC –

Patient Medical History Form

PATIENT INFORMATION

Last name: _____ **First name**: _____ **Middle initial**: _____ **DOB**: _____

Preferred Pharmacy (Name and City): _____

Medications (include over-the-counter medications): ***** Please bring in all of your medications to your first appointment *****

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any Allergies? ☐ **Yes** ☐ **No** **If yes, please list what you are allergic to and what happens.**

Allergen Reaction

_____

_____

Past Medical History (what have you been treated for currently or in the past, ie. Hypertension):

_____

_____

_____

_____

_____

Past Surgical History (please list all surgeries to include childhood):

_____

_____

_____

_____

_____

Hospitalizations (Have you ever stayed in the hospital overnight? Please include the date (mo/yr) and why:

Date Reason

_____

_____

_____

_____

Family History:

Father: ☐ living age____ ☐ deceased Medical Conditions: _____

Mother: ☐ living age____ ☐ deceased Medical Conditions: _____

Paternal Grandfather: ☐ living age____ ☐ deceased Medical Conditions: _____

Paternal Grandmother: ☐ living age____ ☐ deceased Medical Conditions: _____

Maternal Grandfather: ☐ living age____ ☐ deceased Medical Conditions: _____

Maternal Grandmother: ☐ living age____ ☐ deceased Medical Conditions: _____

Brother(s): ☐ living age____ ☐ deceased Medical Conditions: _____

Sister(s): ☐ living age____ ☐ deceased Medical Conditions: _____

Social History:

Do you smoke or did you ever smoke? ☐ Yes ☐ No If yes:

What year did you start? _____

What year did you quit? _____

How often do you smoke? ☐ Every day ☐ Some days, but not every day

How many cigarettes do you smoke a day? _____

How soon after waking do you smoke your first cigarette? (Circle one): 5min or less 6-10min 11-20min 21-30min 31+min

Are you interested in quitting? ☐ Yes ☐ No

Social History (continued):

Did you have a drink containing alcohol in the last 12 months? ☐ Yes ☐ No If yes:

How often did you drink? (Circle one): Monthly or less 2-4x/month 2-3x/week Daily or almost daily

How many drinks did you have on a typical day? (Circle one): 1-2 3-4 5-6 7-9 10 or more

How often do you have 6 or more drinks in a day? (Circle one): Never 0-1x/month 2-4x/month 2-3x/week 4-7x/week

Do you use drugs not prescribed to you by a medical doctor? ☐ Yes ☐ No If yes:

Please list those drugs: _____

Do you drink caffeine? ☐ Yes ☐ No If yes:

How many cups do you drink a day? (Circle one): 1-2 2-3 3-4 >4

Do you smoke or ingest marijuana? ☐ Yes ☐ No

What is your marital status? (Circle one): Single Married Separated Divorced Living with significant other Widowed

Number of adults in household? _____

Number of children in household? _____

Over the past 2 weeks, how often have you been bothered by:

Little interest or pleasure in doing things? (Circle one): Not at all Several days More than half the days Nearly every day

Feeling down, depressed or hopeless? (Circle one): Not at all Several days More than half the days Nearly every day

Preventative Medicine:

Not all tests/studies/immunizations will be applicable to you. When was your last?

Mammogram: _____

Pap Smear: _____

Colorectal Cancer Screening: _____ (choose one): Hemoccult Colonoscopy Cologuard

Prostate Cancer Screen (PSA): _____

Bone Density Screening (DEXA Scan): _____

Cholesterol Screening (Lipid Panel): _____

Influenza immunization (Flu shot): _____

Tetanus Immunization (TdaP): _____

Zoster Immunization (Shingles shot): _____

Pneumococcal Immunization (PCV20, PCV21, PPSV23): _____

Patient Signature: _____ **Date**: _____