Integrity Primary Med
Patient Oriented Family Practice

PATIENT MEDICAL HISTORY Today's Date:_____

FIRST NAME:_____ **MI:**_____ **LAST NAME:**_____

Date of Birth: _____/_____/_____ Sex: M / F Social Security Number: _____-_____-_____

CURRENT MEDICATIONS (include all non-prescription products) ❑No Current Medications

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

10._____ 11._____ 12._____

ALLERGIES (include medication, food, latex and environmental allergies) ❑No Known Allergies

Allergy 1:_____Reaction:_____ Severity: ❑mild ❑moderate ❑severe

Allergy 2: _____ Reaction: _____ Severity: ❑mild ❑moderate ❑severe

Allergy 3:_____Reaction:_____ Severity: ❑mild ❑moderate ❑severe

Allergy 4:_____Reaction:_____ Severity: ❑mild ❑moderate ❑severe

Allergy 5:_____Reaction:_____ Severity: ❑mild ❑moderate ❑severe

PERSONAL MEDICAL HISTORY (check all that apply)

❑ADHD
❑Alcoholism
❑Allergies, Seasonal
❑Anemia or other blood disease
❑Anxiety
❑Arrhythmia (irregular heartbeat)
❑Arthritis
❑Asthma
❑Back pain
❑Bipolar
❑Bladder problems / Incontinence
❑Bleeding problems
❑Cancer:_____
❑Crohn's Disease
❑COPD
❑Dementia
❑Depression
❑Diabetes: 1 or 2
❑Diverticulitis
❑DVT (Blood clot)
❑GERD (acid reflux)
❑Glaucoma
❑Heart attack (MI)
❑Heart disease
❑Hepatitis
❑HIV
❑Hiatal hernia
❑High blood pressure
❑High cholesterol
❑Kidney stones
❑Kidney disease
❑Lupus
❑Liver disease
❑Prostate
❑Macular Degeneration
❑Neck pain
❑Neuropathy
❑Osteopenia /Osteoporosis
❑Parkinson's disease
❑High cholesterol
❑Peripheral vascular disease
❑Peptic ulcer
❑Psoriasis
❑Pulmonary embolism
❑Rheumatoid arthritis
❑Seizures
❑Severe headaches
❑Sleep apnea
❑Stomach disease
❑Stroke
❑Thyroid disease
❑Lung disease

Patient History, Page 2 Today's Date:_____

FIRST NAME:_____ **MI:**_____ **LAST NAME:**_____

OTHER MEDICAL ISSUES (not listed above): _____

_____

Last Menstrual Period: Date:_____ ❑Normal ❑Abnormal

Mammogram: ❑Yes ❑No Date:_____ ❑Normal ❑Abnormal

Pap: ❑Yes ❑No Date:_____ ❑Normal ❑Abnormal

DEXA (Bone Density): ❑Yes ❑No Date:_____ ❑Normal ❑Abnormal

Colonoscopy: ❑Yes ❑No Date:_____ ❑Normal ❑Abnormal

SURGICAL HISTORY (list all prior surgeries and approximate dates):

_____

_____

_____

HOSPITALIZATIONS:

Year:_____ Hospital: _____ Reason: _____
Year:_____ Hospital: _____ Reason: _____
Year:_____ Hospital: _____ Reason: _____
Year:_____ Hospital: _____ Reason: _____
Year:_____ Hospital: _____ Reason: _____

FAMILY HISTORY:

Mother: ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Father: ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Brother: ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Sister: ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Grandmother(M): ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Grandfather(M): ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Grandmother(P): ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A
Grandfather (P): ❑High Blood Pressure ❑Diabetes ❑Cancer ❑Other:_____ ❑N/A

IMMUNIZATIONS:

Influenza (18 years of age and older)? ❑Yes ❑No If yes, date:_____
Pneumococcal (65 years of age and older)? ❑Yes ❑No If yes, date:_____
DPT/TdaP/Tetanus? ❑Yes ❑No If yes, date:_____
MMR: If yes, date:_____ Shingles (Zoster/Shingrix): If yes, date:_____
COVID: If yes, date(s):_____

Current Community Services?❑Yes ❑No _____
Current Home Health or Hospice Services?❑Yes❑No _____
Any Device with 2 way visual and voice communication (cell phone, tablet)? ❑Yes ❑No

Patient History, Page 3 Today's Date:_____

FIRST NAME:_____ MI:_____ LAST NAME:_____

SOCIAL/CULTURAL HISTORY:

Education Level: ❑Elementary ❑High School ❑Vocational ❑College ❑Graduate/Professional

Occupation:_____

Preferred Language: _____ Interpreter Needs? ❑Yes ❑No _____

Are there any vision difficulties that affect your communication? ❑Yes ❑No _____

Are there any hearing difficulties that affect your communication? ❑Yes ❑No _____

Are there any limitations to understanding or following instructions (written or verbal)? ❑Yes ❑No _____

Current Living Situation (check all that apply): ❑Single Family Home ❑Multi-generational household ❑ALF ❑ILF ❑Homeless ❑Shelter ❑Skilled Nursing Facility ❑Other:_____

Smoking/Tobacco Use: ❑Current ❑Past ❑Never
Type:_____ Amount/Day:_____ Number of years:_____ Quit Date: _____

Alcohol: Type/Frequency:_____ Past History of Alcohol Abuse?_____

Recreational Drug Use: ❑Current ❑Past ❑Never Type:_____ Are you sexually active? ❑Yes ❑No

Are there any safety concerns in the home: Weapons? ❑Yes ❑No | Pets? ❑Yes ❑No | Obstructions? ❑Yes ❑No

Do you feel safe in your home? ❑Yes ❑No Is anyone physically or emotionally abusing you? ❑Yes ❑No

Are there any financial issues that directly impact your ability to manage your health? ❑Yes ❑No

How often do you get the social and emotional support you need? ❑Always ❑Usually Sometimes ❑Rarely ❑Never

Do you have any spiritual needs that affect your health? ❑Yes ❑No

Comments (Please feel free to comment on any answers marked "yes" above: _____

_____

_____

OFFICE USE - ADDITIONAL NOTES: