ASHLAND FAMILY PRACTICE
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Health History Information

Today's Date: _____

Patient Name: _____ **Patient ID#:** _____

Occupation: _____ **Birthdate:** _____

Preferred Local Pharmacy: _____ **Mail Order Pharmacy:** _____

Advance Directive on file with us? No__ Yes__ **POLST form on file with us? No__ Yes__**

Past Medical History

Have you ever had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Congestive Heart Failure..	No__ Yes__	Polio……..	No__ Yes__	Infectious Mono…….	No__ Yes__
Atrial Fibrillation……..…	No__ Yes__	Glaucoma……..	No__ Yes__	Bronchitis……	No__ Yes__
Coronary Artery Disease...	No__ Yes__	Hernia……	No__ Yes__	Mitral Valve Prolapse…..…	No__ Yes__
Valvular Disease……	No__ Yes__	Blood or Plasma		Stroke……..	No__ Yes__
Arthritis…….....	No__ Yes__	Transfusions……	No__ Yes__	High Cholesterol……..…	No__ Yes__
Venereal Disease……	No__ Yes__	Back Trouble…….	No__ Yes__	If yes, last checked	_____
Anemia…….....	No__ Yes__	High Blood Pressure……..	No__ Yes__	Hepatitis……..	No__ Yes__
Bladder Infections……..	No__ Yes__	Low Blood Pressure……..	No__ Yes__	Ulcer……...	No__ Yes__
Epilepsy……..	No__ Yes__	Hemorrhoids……..	No__ Yes__	Kidney Disease……..	No__ Yes__
Migraine Headaches.....	No__ Yes__	Asthma…….....	No__ Yes__	Thyroid Disease……	No__ Yes__
Diabetes I or II……..……..	No__ Yes__	Hives or Eczema……	No__ Yes__	If yes, last thyroid panel	_____
Last Foot/Eye Exam	_____	AIDS or HIV +……..	No__ Yes__	Bleeding Tendency…….....	No__ Yes__
Hemoglobin A1c	_____	Implanted Device or Metal	No__ Yes__	Cancer……	No__ Yes__
		If yes, type_____		If yes, type_____	

Previous Hospitalizations/Surgeries/Serious Illness	When?	Hospital, City, State

Medications: (Include nonprescription/supplements) _____

_____

_____

Allergies

List the following allergies, indicating any reactions:

Medications: _____

Environmental/Known Food Allergies: _____

Patient Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously ☐ Tobacco - packs/day_____ ☐ Other _____

Substance abuse: ☐ Never ☐ Type/Frequency_____ ☐ Last used _____

Excessive exposure at home/work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne Particles ☐ Noise

Sexually Active: ☐ No ☐ Yes - # of partners in the last 12 mo._____ Sexual preference: ☐ Female ☐ Male

Recent Travel: ☐ No ☐ Yes - Where/When?_____

Family Medical History

	Age	Age at Onset	Diseases	If Deceased, Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				
Grandfather				
Grandmother				

Immunizations

List the date that you last received the following immunizations:

☐ Tetanus _____ ☐ Pneumovax _____ Hepatitis B 3-dose series: ☐ 1 ☐ 2 ☐ 3 complete

☐ Influenza (Flu) _____ ☐ Prevnar 13 _____ Shingrix 2-dose series: ☐ 1 ☐ 2 complete

☐ HPV _____

Preventative Screenings

List the date of your last screening:

☐ PSA (prostate cancer)	_____	☐ Mammogram	_____	☐ Colonoscopy	_____
☐ Pap	_____	☐ Dexa (bone density)	_____	☐ Hepatitis C	_____
☐ HIV	_____	☐ iFOBT (blood in stool)	_____	☐ Abdominal Aortic Aneurysm (AAA)	_____
☐ Chest X-ray	_____	☐ Lung CT	_____		

Other Health Care Providers

Please list any other Care Providers you are currently seeing:_____

_____

Reproductive History

Female

Age of Menarche: _____ Last Menstrual Period: _____

Number of Pregnancies: _____ Number of Live Births:_____

History of Breastfeeding? ☐ No ☐ Yes If yes, number of months: _____

Are you currently using contraceptives? ☐ No ☐ Yes If yes, which method: _____

Tubal Ligation? ☐ No ☐ Yes If yes, when? _____

Pre/Post-Menopausal? ☐ No ☐ Yes If yes, age of menopause: _____

Male

Vasectomy? ☐ No ☐ Yes If yes, when?_____