

Patient Medical History Form

Please complete as thoroughly as possible. This information helps us provide safe, personalized care.

Please Note: Please print this completed form and bring it to your appointment. Do not return this form by email or upload it online.

Patient Name *

Date of Birth *

Today's Date *

REASON FOR TODAY'S VISIT

Chief Complaint / Reason for Visit

ALLERGIES

List all medication, food, and environmental allergies and the reaction they cause. Write "NKDA" (No Known Drug Allergies) if none.

Allergen	Reaction

PRESCRIPTION HISTORY CONSENT

I hereby grant permission to Access Family Care, LLC to view my prescription history from external sources.

Signature

Date

CURRENT MEDICATIONS

Include prescription drugs, over-the-counter medications, vitamins, and supplements.

Medication Name	Dose	Frequency	Prescribing Provider

MEDICAL HISTORY — CHECK ALL THAT APPLY

- | | |
|---|--|
| ☐ NONE | ☐ Anemia |
| ☐ Allergies | ☐ COPD / Emphysema |
| ☐ Asthma | ☐ Hypothyroidism |
| ☐ Cancer (type) | ☐ Migraine Headaches |
| ☐ Reflux | ☐ Seizure Disorder |
| ☐ Gout | ☐ Stroke / TIA (history of) |
| ☐ Hepatitis | ☐ Arthritis |
| ☐ HIV | ☐ Diabetes |
| ☐ Hypertension | ☐ Heart Disease |
| ☐ Kidney Disease | ☐ High Cholesterol |
| ☐ Thyroid Disease | ☐ Liver Disease |
| ☐ Lupus | ☐ Testosterone (Low) |
| ☐ Psychiatric Disorder | |

Other / Cancer Type (Please Specify)

PREVIOUS SURGERIES

Have you undergone any of these surgical procedures? Check all that apply.

- | | |
|--|---|
| ☐ Appendectomy | ☐ Breast Surgery |
| ☐ Hysterectomy | ☐ Joint Surgery |
| ☐ Thyroid Surgery | ☐ Tonsillectomy |
| ☐ Gallbladder | ☐ Other |

If Other, Please Specify

FAMILY HISTORY

List any family members (parents, grandparents, aunts, uncles, siblings, and/or children) who have the following conditions.

Cancer☐ Yes☐ No

Type(s)

Relationship (Alive/Deceased)

Diabetes☐ Yes☐ No

Relationship (Alive/Deceased)

Heart Disease☐ Yes☐ No

Relationship (Alive/Deceased)

High Blood Pressure☐ Yes☐ No

Relationship (Alive/Deceased)

High Cholesterol☐ Yes☐ No

Relationship (Alive/Deceased)

Kidney Disease☐ Yes☐ No

Relationship (Alive/Deceased)

Thyroid Disease☐ Yes☐ No

Relationship (Alive/Deceased)

Other☐ Yes☐ No

Relationship (Alive/Deceased)

SOCIAL HISTORY

Occupation

Marital Status

Tobacco Use:☐ Never☐ Former (quit date below)☐ Current

Packs per Day / Quit Date (if applicable)

Alcohol Use:☐ Never☐ Occasional☐ Regular

Drinks per Week (approx.)

Recreational / Non-Prescribed Drug Use:☐ Never☐ Former☐ Current

Please Describe (substance, frequency)

IMMUNIZATIONS*Have you received any of the following vaccines? If yes, please list the approximate date received.*

Influenza (Flu Vaccine)

Shingles

Pneumonia

HPV

Tetanus

Covid

Other

OB/GYN HISTORY (IF APPLICABLE)

Number of Pregnancies

Number of Children

Number of Miscarriages/Abortions

Are You Currently Pregnant or Could You Be Pregnant?

Date of Last Menstrual Period

Birth Control

Age of First Menses / Age of Menopause

SCREENINGS / PREVENTIVE HEALTH*Please list the date of your last screening exam, if applicable.*

Colonoscopy

Mammogram

Pap Smear

Prostate Exam

Bone Density

Date of Last Physical / Dental / Eye Exam

Other

Up to Date on Recommended Vaccinations? (Y/N, list any known)

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

- ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

PATIENT ATTESTATION

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I understand that this information will be used by my care team to guide my diagnosis and treatment, and I will notify Access Family Care, LLC of any changes to my health history.

Patient / Guardian Printed Name *

Date *

Signature *

Date *