Corridor Primary Care, P.A.
Patient History Form

Name (Please print): _____ Age: _____ Date of Birth: _____

Form completed by: _____ Today's date: _____

ALLERGIES (List substance and reaction)

Drugs _____

Food _____

Other (bees, latex, vaccines, etc.) _____

MEDICATIONS I TAKE (List prescriptions and over-the-counter products – use other side if necessary)

Name	Dose/How often	Name	Dose/How often
_____		_____	
_____		_____	
_____		_____	
_____		_____	

MEDICAL HISTORY

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke or Mini-stroke (TIA)
- ☐ Blood clot
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Heart failure
- ☐ Enlarged prostate
- ☐ Erectile dysfunction
- ☐ Frequent urinary infections
- ☐ Overactive bladder
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Abuse
- ☐ STI: Type?
- ☐ Diabetes with insulin
- ☐ Diabetes without insulin
- ☐ Thyroid: High? Low?
- ☐ Anemia
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Positive TB test
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Acid reflux/GERD
- ☐ Bleeding ulcer
- ☐ Hearing loss
- ☐ Depression
- ☐ Anxiety
- ☐ Hepatitis (type?)
- ☐ Osteoarthritis
- ☐ Rheumatoid/other arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Connective tissue disease
- ☐ Osteoporosis
- ☐ Peripheral nerve disease
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Seizures
- ☐ Memory loss/Dementia
- ☐ Migraines: with aura? Yes No
- ☐ Blood transfusion (when?) _____
- ☐ Other:

(treatment?)

☐ ADD/ADHD: When Diagnosed? _____ By whom? _____

☐ Vitamin Deficiency: Types? _____

☐ Hormone Deficiency: Types? _____

☐ Cancer: Types? _____

☐ Serious Injuries: Types? _____

List any **SPECIALISTS** you see: _____

List any **SURGERIES** you have had: _____

FAMILY HISTORY (list who: Mother, Father, Maternal/Paternal Grandparents, Brother, Sister or Child)

High Blood Pressure _____ Diabetes Type 1 _____ Stroke _____

High Cholesterol _____ Diabetes Type 2 _____ Alzheimer's _____

Heart Disease _____ Osteoporosis _____ Colon Cancer/Polyps _____

Breast Cancer _____ Prostate Cancer _____

Other Cancer (Type?) _____ Psychiatric Disorder _____

Thyroid Disease _____ Other inherited problems _____

SOCIAL HISTORY (Check all that apply)

- ☐ Single
- ☐ Married: How long? _____
- ☐ Divorced: When? _____
- ☐ Widowed: When: _____
- ☐ Partnered: How long? _____

Number of children: _____

Faith preference: _____

Hobbies/Interests: _____

Current/Former occupation: _____

Last grade level attended: _____

Are you a:

- ☐ Student? Where: _____
- ☐ At home caregiver? For whom: _____
- ☐ Employed? _____
- ☐ Disabled? Cause: _____
- ☐ Did you move here from another country?
  Country(s): _____
- ☐ I have an Advance Directive document

HEALTH HABITS

- ☐ Never used tobacco
- ☐ Use e-cigarettes
- ☐ Use tobacco now: Type(s) _____ ; #packs/containers daily _____ ; #years/age you started _____
- ☐ Quit tobacco: Type(s) _____ Date/Age quit _____ ; #years used/age you started _____

Alcohol? Type(s) _____ ; #drinks/week _____ ; #years/age started _____

Recreational substances? Currently using _____

Formerly used _____ Treatment required (circle)? Yes No

Exercise routine (describe)? None, or _____

Special diet? _____

Other regular healthcare practices? _____

IMMUNIZATIONS - Please write the date of your most recent vaccine (if known)

Influenza _____ Tetanus _____ Meningitis _____ Shingles. _____

Pneumonia _____ Have you had 2 of these? No Yes

Hepatitis A _____ Have you completed the series of 2? No Yes

Hepatitis B _____ Have you completed the series of 3? No Yes

HPV (Gardisil) _____

SCREENING TESTS - Please write the date of your most recent test (if known)

Chest X-ray _____ Colonoscopy _____ EKG _____

Bone Density _____ Sleep study _____ Lung Function _____

To the best of my knowledge the statements and answers on this form are true, complete and correct.

_____ _____

Patient or Guardian's signature Date

WOMEN ONLY

Date of last menstrual period _____

Age your periods began _____

Are your periods regular? Yes No

Are your periods Heavy Moderate Light

Are your cramps Severe Mild None

Date of last Pap smear _____

Date of last mammogram _____

Do you check your breasts monthly? Yes No

How many times have you been pregnant? _____

Number of deliveries: Vaginal _____ C-Section _____

Any Tubal Pregnancies? Yes No

Miscarriages Yes No

Stillbirths Yes No

Abortions Yes No

Complications with pregnancies? Yes No

Any abnormal vaginal discharge? Yes No

To the best of my knowledge the statements and answers on this form are true, complete and correct.

_____ _____

Patient or Guardian's signature Date

Please return to receptionist or nurse when completed and signed. Thank you