Patient Name: _____ Gender Identity: M F Legal Sex: M F DOB: _____

Address: _____ Marital Status: _____

Phone: _____ Email: _____

Emergency contact name: _____ Phone: _____

HEALTH HISTORY

Do you or have you experienced the following:

Anemia	Y	N	Heart Problems	Y	N	Mitral Valve Prolapse	Y	N
Anxiety Disorder	Y	N	Hepatitis	Y	N	MRSA	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Osteoporosis	Y	N
Cancer	Y	N	Hyperthyroid	Y	N	Seizures	Y	N
Depression	Y	N	Hypothyroid	Y	N	Stress Incontinence	Y	N
Diabetes	Y	N	Lupus	Y	N	Stroke	Y	N
Other: _____						Abnormal Pap	Y	N

If yes above, explain: _____

_____

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TEST

Hospitalization / Surgery / Diagnostic Test	Date	Hospitalization / Surgery / Diagnostic Test	Date

SOCIAL HISTORY

Second hand smoke exposure ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No Packs or Cans Per Day _____ For How Long? _____ Date Quit _____

Alcoholic Beverages Amount_____ Frequency_____ Cups of Coffee per Day_____ Pop or Tea per Day_____

Have you used street drugs? ☐ Yes ☐ No Have you used IV drugs? ☐ Yes ☐ No

Total # of children in home _____ Total # of pregnancies_____ # of abortions_____ # of miscarriages_____ # of premature births_____

# of living children: _____ # of full-term babies: _____

How many vaginal births have you had: _____ How many cesarean births have you had: _____

Any complications of pregnancy:

Are you afraid of anyone at home? ☐ Yes ☐ No

FAMILY HISTORY

Do your blood relatives have any of the following: (Please note which relative and whether Maternal (mother) or Paternal (father)).

			Relationship				**Relationship**
Cancer _____	Y	N	_____	MRSA	Y	N	_____
Cancer _____	Y	N	_____	Heart Disease	Y	N	_____
Blood Clotting Disorder	Y	N	_____	High Blood Pressure	Y	N	_____
Diabetes	Y	N	_____	Osteoporosis	Y	N	_____
Other: _____				Stroke	Y	N	_____

Place Patient Label Here

Epic: ENC level to Patient Intake - Scan
Description: Health History
Form M5138 (Rev. 06/21)

PREVENTIVE SCREENINGS

			Date/Results
Mammogram	Y	N	
Bone Density Study	Y	N	
Colonoscopy-Bowel Study	Y	N	
Lipid/Cholesterol Screen	Y	N	
Pap Smear	Y	N	

OTHER HEALTHCARE PROVIDERS YOU SEE:

ALLERGIES

Are you allergic to any of the following:

			Reaction
No Known Drug Allergies	Y		
Aspirin	Y	N	
Barbituates	Y	N	
Codeine	Y	N	
Erythromycin	Y	N	
Iodine	Y	N	
Jewelry	Y	N	
Latex	Y	N	
Methergine	Y	N	
Morphine	Y	N	
Novocain	Y	N	
Penicillin	Y	N	
Sedatives	Y	N	
Sulfa Drugs	Y	N	
Tetracycline	Y	N	
Tylenol	Y	N	
Valium	Y	N	
Food Allergy	Y	N	
Seasonal/Environmental	Y	N	
Other:			

IMMUNIZATIONS

Are you currently updated on all immunizations? Please circle one: YES NO UNSURE

	Date (if you remember)
Last Influenza	
Last Pneumonia	
Last TB Skin Test	
Last Tetanus	

			Date (if you remember)
Varicella	Y	N	
Hepatitis B	Y	N	
MMR	Y	N	
HPV	Y	N	
Zostavax	Y	N	
Other:			

LIST ANY PRESCRIPTION, HERBAL OR OVER-THE-COUNTER MEDICATIONS YOU TAKE AND DOSES YOU ARE USING

Drug	How Often	What For