BAPTIST Primary Care
Julington Creek

MEDICAL HISTORY

Patient Name:_____ Today's Date: _____
Date of Birth:_____ Age: _____ Male / Female Phone number:_____
Referring Physician:_____ Primary Care Physician:_____
Other Treating Physician(s):_____

PERSONAL HISTORY:

History of Present Illness (Describe all in detail what is bothering you, when started, treatments, tests performed):

_____
_____
_____

Past Medical History (List all hospitalizations & illnesses you have been treated for, e.g. diabetes, hypertension, heart disease etc.)

_____
_____
_____

Past Surgical History (List all operations and major injuries):

_____
_____
_____

Allergies and Adverse Reactions (Include allergies to Antibiotics, Latex, X-ray, Dye, Skin Preps, Pain Medications etc.)

_____
_____

Blood Transfusions: I will accept blood products in an emergency ☐YES ☐NO
Have you ever had transfusion reactions? ☐YES ☐NO

CURRENT MEDICATIONS: (Include Insulin, Birth Control, Supplements, Steroids, Inhalers, Oxygen, Vitamins, Eye Drops etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐____# of Children ☐Divorced since_____ ☐Widowed since_____
Living Will (HCAD): ☐YES ☐NO ☐Retired ☐Occupation:_____
Tobacco: ☐None ☐Currently smoke_____ packs/day and have done so for _____years ☐Smokeless tobacco
☐Previously smoked_____ packs/day for _____years. Stopped in _____
Alcohol: ☐None ☐Previously Heavy ☐_____servings daily Caffeine: ☐None ☐_____servings daily
Drug Use: ☐Marijuana ☐Cocaine ☐Crack ☐Heroin ☐Other (list)_____

FAMILY HISTORY: (Please include diabetes, cancer, heart disease, hypertension, breast or ovarian cancer)

	ALIVE / DECEASED	AGE	HEALTH PROBLEMS / CAUSE OF DEATH
Father			
Mother			
Brothers/Sisters			

Please provide the date when you last had any of the following Exams/Tests/Vaccines done:

Physical Exam_____ Blood Work_____ EKG_____ Colonoscopy_____ PSA _____
Mammogram_____ PAP_____ Bone Density_____
Flu Vaccine_____ Pneumonia_____ Zostavax_____ A1C_____ Hep B_____ Tetanus_____ HPV_____