Health and Medication History

BAPTIST Primary Care

Changing Health Care for Good.®

Patient Name: _____ Today's Date: _____

Age: _____Date of Birth:_____ Home Phone: _____ Cell Phone: _____

Other Treating Physicians: _____

Pharmacy Name and Phone #:_____

Mail Order Name and Phone #:_____

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

_____

_____

_____

Past Medical History *(List all hospitalizations and illness for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, 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 if applicable)*_____

_____

_____

Current Medications *(Include insulin, steroids, inhalers, oxygen, eye drops, etc.)*

Drug	Dose	Frequency	Drug	Dose	Frequency

Social History *(Check all that apply)*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Children: ☐ Yes ☐ No Number of Children _____

Advanced Directives: ☐ Yes ☐ No

Occupation: _____

Tobacco: ☐ None ☐ Currently smoke _____ packs/day and have done so for _____ years

☐ Previously smoked _____ packs/day for _____ years

Stopped in _____ ☐ Smokeless tobacco

Alcohol: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy

Caffeine: ☐ None ☐ 1-3 servings daily ☐ 4-6 servings daily ☐ More than 6 servings daily

Drug Use: ☐ None ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Other _____

Family History *(Please include history of diabetes, heart disease, hypertension, or cancer)*

	Alive/Deceased	Age	Health Problems
Father			
Mother			
Brother/Sisters			

Is there a family history of breast or ovarian cancer? *(Who, at what age, breast or ovarian)*

_____

_____

_____

Baptist Primary Care – Nocatee
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