CareMedica

Patient Medical History Intake Form

Patient Name: _____DOB: _____ Today's Date:_____

Reason for Today's Visit:

❑ New Patient ❑ Illness ❑Pre-Surgical Clearance
❑Hospital Discharge Follow-Up ❑ Work Injury ❑ Auto Accident
❑ Hormone Replacement ❑Medically Supervised Weight Loss Program

Preferred Pharmacy:_____ Pharmacy Phone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

Current/Previous Primary Care Provider(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Current/Previous Specialists:

Cardiologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Any Current Concerns? _____

Allergies and sensitivities to medications, food, animals, other. Please include the reactions:

_____

_____

_____

❑ No known allergies

Medication Name	Frequency	As of	Prescriber

ALL current medications (List all prescription and non-prescription medications, contraceptives, vitamins, and supplements):

❑ Not taking medications

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia	☐	☐	HIV/AIDS/Hepatitis	☐	☐
Asthma	☐	☐	Hypo/Hyperthyroidism	☐	☐
Blood Clot/DVT	☐	☐	Lyme Disease	☐	☐
Cancer:	☐	☐	Osteoporosis/Osteopenia	☐	☐
COPD	☐	☐	Peripheral Vascular Disease	☐	☐
Diabetes Type I/Type II	☐	☐	Psoriasis	☐	☐
Gout	☐	☐	Renal Failure/Kidney Disease	☐	☐
Heart Attack/Angina	☐	☐	Rheumatoid Arthritis/Lupus	☐	☐
Heart Disease/Pacemaker	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐
History of Blood Transfusion	☐	☐	Ulcer/Acid Reflux/GERD	☐	☐
History of Prednisone or Steroid Medication	☐	☐	Other:	☐	☐

PAST SURGERIES	REASON	SURGEON	DATE

PAST HOSPITALIZATIONS	REASON	DATE

Preventative Care

Please list the date of your most recent, if unknown please check unknown:

Complete Physical:	Date:	❒Unknown
Colonoscopy:	Date:	❒Unknown
Dental Cleaning:	Date:	❒Unknown
Eye Exam:	Date:	❒Unknown
COVID Vaccine:	Date:	❒Unknown
COVID Booster:	Date:	❒Unknown
Tuberculosis Test:	Date:	❒Unknown
Tetanus Immunization:	Date:	❒Unknown
Prevnar 13:	Date:	❒Unknown
Pneumovax 23:	Date:	❒Unknown
Shingles:	Date:	❒Unknown
HPV:	Date:	❒Unknown
Meningitis:	Date:	❒Unknown
TDAP:	Date:	❒Unknown
Influenza Vaccination:	Date:	❒Unknown
Measles Immunization:	Date:	❒Unknown
Hepatitis A Immunization:	Date:	❒Unknown
Hepatitis B Immunization:	Date:	❒Unknown

Family History

Relationship	Living or Deceased?	Please list any inherited diseases, chronic illness or cause of death
Mother		
Father		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brothers		
Sisters		
Sons		
Daughters		

Social History

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

What do you consider your stress level is? ❒Low ❒Medium ❒High

Do you have a family history of medical, mental, or hereditary problems? ❒Yes ❒No
Please list:_____

_____

_____

Travel Outside the U.S within the past three years? ❒Yes ❒No

Where and when?_____

_____

Do you have a living will? ❒Yes ❒No

Is your time well balanced between your jobs, family and hobbies? ❒Yes ❒No

Do you wear seat belts? ❒Always ❒Usually ❒Occasionally ❒Never

If you ride a bicycle or motorcycle, do you wear a bike helmet? ❒Yes ❒No

Do you have frequent falls? ❒Yes ❒No

If there is a gun in your home, is it out of children's reach and unloaded? ❒Yes ❒No

If you are a female, do you do a monthly self-breast exam? ❒Yes ❒No

If you are a male, do you do a monthly self-testicular exam? ❒Yes ❒No

Do you practice "safe sex"? ❒Yes ❒No

Have you used illegal drugs? ❒Yes ❒No

How would you describe your dietary intake? _____
_____

How many cups of coffee or caffeinated drinks do you drink daily? _____

What (if any) physical activity/exercise do you engage in and how often?_____
_____
_____

Do you smoke? ❒Now ❒Past ❒Never
If so, how many per day and for how long? _____

How much alcohol do you drink? _____per day _____per week
If yes, how many times in the past month have you had more than 4 alcoholic drinks in one day?
_____

Are you currently experiencing any of the following? Please circle all that apply:

Loss of interest in things you used to enjoy
Chronic sadness
Problems concentrating/decision making
Restlessness, inability to sit still
Hopelessness
Thought of death/suicide.
Feelings of worthlessness, guilt.
Loss of energy/exhaustion.
Changes in appetite.
Other: _____

For Females Only

Last Menstrual Period: _____ Length of Period: _____

Form of Birth Control: _____

Last Pap Smear: _____

Provider: _____ Phone # _____

Last Mammogram: _____

Ordering Provider: _____ Phone #: _____

Are you experiencing or actively in menopause? Yes or No (circle one)

Last Pregnancy: _____

Have you ever had any miscarriages? Yes or No (circle one) If yes, how many_____.

Live Births? Yes or No If yes, how many _____.

Terminations? Yes or No (circle one) If yes, how many_____.