PINNACLE FAMILY PRACTICE

Please Print

11/5/12

# Medical History

**Name**:_____

**ALL MEDICATIONS w/ DOSAGE & Vitamins:** ☐None

_____
_____
_____
_____
_____
_____
_____
_____

**ALLERGIES /REACTIONS:** ☐None

Med/food reaction

_____
_____
_____

**HOSPITALIZATIONS/SURGERIES:** ☐None

Reason Year

_____
_____
_____
_____
_____
_____

**CURRENT & PAST HEALTH PROBLEMS:** ☐None

Problem Year diagnosed

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**SPECIALISTS SEEING:** ☐None

Name Phone#

_____
_____
_____
_____
_____
_____

****PREFERRED PHARMACY:**

**Name:**_____
**Address:**_____
_____
**Phone:**_____ **Fax**_____

**SOCIAL INFORMATION:**

**Alcohol consumption**: ☐None
Type:_____
Number of drinks per week:_____

**Tobacco Consumption**: ☐Never
☐ Current use ☐ Previous use, quit date:_____
Type: ☐ Cigarettes ☐ Cigars/Pipe ☐ Chewing tobacco
# of packs/times per day:_____

**Diet**: ☐ Vegan ☐ Vegetarian ☐ other:_____

**Exercise**: ☐ None
Type:_____
Amount:_____

**Country of Birth**: ☐ USA ☐ _____

**Highest level of education**:
☐ High School ☐ College ☐ Graduate School

**Job/Profession**: _____
**Employer/location**:_____

**How much Stress do you experience from the following**:

| | | | |
|---|---|---|---|
| Job/Employer: | ☐ Low | ☐ Moderate | ☐ High |
| Finances: | ☐ Low | ☐ Moderate | ☐ High |
| Home Life: | ☐ Low | ☐ Moderate | ☐ High |

**Household information**
Number of those living with you _____
Ages of those living with you _____

**Number of Children:** _____

**How did you hear about our practice:**
☐ Insurance company ☐ Phone book ☐ Web
☐ referral from a friend ☐
other:_____

PINNACLE FAMILY PRACTICE

## Family History:

| | **Health problems** (Ex: Diabetes, Cancer, etc) or write **Healthy** or **Unknown** |
|---|---|
| Father: | |
| Mother: | |
| Brothers: | |
| Sisters: | |
| Son: | |
| Daughter: | |
| Paternal Grandfather: | |
| Paternal Grandmother: | |
| Maternal Grandfather: | |
| Maternal Grandmother: | |
| Other: | |

## Health Medical History (List dates of last tests/shots):

| Exam/Test | Date | Results |
|---|---|---|
| Physical Exam | | ☐ Normal ☐ not normal (explain): |
| Cholesterol screen | | ☐ Normal ☐ not normal (explain): |
| Colonoscopy | | ☐ Normal ☐ not normal (explain): |
| PSA/ exam (men only) | | ☐ Normal ☐ not normal (explain): |
| Mammogram (women only) | | ☐ Normal ☐ not normal (explain): |
| Pap Smear (women only) | | ☐ Normal ☐ not normal (explain): |
| Vaccines: | | |
| Tetanus Shot | | |
| Pneumonia Shot | | |
| Shingles Vaccine | | |
| Hepatitis B Vaccine | | |
| Hepatitis A Vaccine | | |

I hereby acknowledge that the information provided on this form is true and accurate to the best of my ability.

Signature_____ Date _____