Bristol Health Medical Group

Today's Date_____

# PATIENT HISTORY INFORMATION

NAME: _____ Date of Birth _____

DRUG ALLERGIES _____

_____

Occupation_____ Marital Status _____ Living Will/Healthcare Directive? Y / N

## PERSONAL HEALTH - Circle all that apply

| | | | | |
|---|---|---|---|---|
| AIDS | Cancer _____ | Gout | Lyme Disease | Rheumatic Fever |
| Alcoholism | Cataracts | Heart Disease | Murmur, Heart | Scarlet Fever |
| Anemia | Chicken Pox | Hepatitis | Measles | Stroke |
| Anorexia | Drug Dependency | Hernia | Migraines | Suicide Attempt |
| Anxiety | Depression | Herpes | Mononucleosis | Thyroid problem |
| Arthritis | Diabetes | High Cholesterol | Multiple Sclerosis | Tuberculosis |
| Asthma | Diverticulitis | High Blood Pressure | Osteoporosis | Ulcers, stomach |
| Bleeding Disorders | Emphysema | HIV Positive | Pacemaker | Vaginal Infection |
| Blood Clots in legs | Glaucoma | Kidney Disease | Pneumonia | Venereal Disease |
| Bronchitis | Goiter | Kidney Stones | Prostate Problems | Other _____ |
| Bulimia | Gonorrhea | Liver Disease | Psychiatric Care | Other _____ |

## MEDICAL HISTORY - List illness/surgery and dates

| | |
|---|---|
| **OTHER CHRONIC ILLNESSES, HOSPITALIZATIONS OR MAJOR SURGERIES & Dates** | |

| **FAMILY HISTORY** | AGE IF LIVING | AGE AT DEATH | PRESENT CONDITION(s) OR CAUSE OF DEATH |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| BROTHERS | | | |
| | | | |
| SISTERS | | | |
| | | | |
| CHILDREN | | | |
| | | | |
| | | | |

**HAS ANY PARENT/SIBLING HAD THE FOLLOWING:**

- ❑ Alcoholism _____
- ❑ Alzheimer's _____
- ❑ Anemia/Low Blood Count _____
- ❑ Lung Problems _____
- ❑ Cancer, Breast _____
- ❑ Cancer, Colon _____
- ❑ Cancer, Prostate _____
- ❑ Cancer, Other _____
- ❑ Heart Disease _____
- ❑ Depression _____
- ❑ Bipolar Disorder _____
- ❑ Diabetes _____
- ❑ Blood Clots _____
- ❑ Hearing Loss _____
- ❑ High Blood Pressure _____
- ❑ High Cholesterol _____
- ❑ Osteoporosis _____
- ❑ Stroke _____
- ❑ Other _____

**IMMUNIZATIONS/VACCINATIONS** (dates)

Flu _____ Tetanus _____ Pneumonia _____ COVID _____
Other _____

**SOCIAL HISTORY**

**Exercise:**
Type/frequency_____
_____
_____

**Smoking:**
Packs/day _____
# of years _____
Year stopped _____

**Alcohol:**
Drinks/day _____
Drinks/week _____

**Recreational Drugs:**
Type/frequency _____
_____

NAME: _____ Date of Birth _____

**PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER & HERBAL SUPPLEMENTS:**

| Medication Name | Medication Dose | # Times per Day | Who Prescribed Med |
|---|---|---|---|
| | | | |
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**We at Bristol Health care about you and our community. Please take a moment to answer these questions. Resources may be available.**

What is your living situation today?
____ I have a steady place to live ____ I am worried about losing my housing ____ I do not have a steady place to live

Do you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc?
____ I don't need any help ____ I could use help (please describe) _____

Do you need assistance with transportation to get to and from medical appointments, work or getting things needed for daily living? ___Yes ___No

**Would you like someone to contact you for further assistance with these social needs? _____ Yes _____ No**