ST. JOSEPH PRIMARY CARE
A MINISTRY OF CARING

Patient Medical History Form

Patient Information	
Name	Date of Birth

Follow Up Visit (only)
Changes since your last visit? ☐ Contact information ☐ Hospital Visit ☐ Changing job ☐ Smoking ☐ Medication(s) ☐ Other
Spiritual Care
Do you feel comfortable to talk about religion with your doctor and/or staff at St. Joseph Primary Care? ☐Yes ☐No

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Allergies- List all known allergies & your body's reactions (Medications, Food, Environment)

☐ **No Known Allergies** ☐ Drug Allergies ☐ Food Allergies ☐ Environmental Allergies

Medical History – Check if you have ever experienced the following conditions and year of onset

Condition	Year	Condition	Year
☐ None		☐ High Cholesterol	
☐ Allergies		☐ Hypertension	
☐ Anemia		☐ High Cholesterol	
☐ Anxiety		☐ Irritable Bowel Disease	
☐ Arthritis		☐ Liver Disease	
☐ Asthma		☐ Osteoarthritis	
☐ Blood Clots		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ Depression		☐ Seizure Disorder	
☐ Diabetes		☐ Thyroid Disease	
☐ Gallbladder Disease		☐ Other	
☐ Heart burn		☐ Other	
☐ Hepatitis C		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.

Exam	Date	Exam	Date
☐ None		☐ Breast Exam	
☐ Influenza Vaccine		☐ Mammogram	
☐ Physical Exam		☐ GYN Exam	
☐ Tetanus Vaccine		☐ PAP Test	
☐ Pneumococcal Vaccine		☐ EKG	
☐ Eye Exam		☐ Colonoscopy	
☐ Pulmonary Function Test		☐ Cardiac Stress Test	
☐ Lipid Panel (Cholesterol)		☐ Echocardiogram	

Surgical History – Check if you have received the following procedures.			
Surgical Procedures	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)			
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Cesarean Section	
☐ Gastric Bypass		☐ D and C	
☐ Hernia Repair		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Family History – Check if any family member(s) has had any of the following conditions.						
☐ Adopted						
Diagnosis	Mother	Father	Sibling	Grandparent	Uncle	Aunt
☐ Alcoholism						
☐ Asthma						
☐ CAD (Heart Attack)						
☐ Cancer – Type:						
☐ CVA (Stroke)						
☐ Depression						
☐ Diabetes						
☐ Hyperlipidemia (High Cholesterol)						
☐ Hypertension (High Blood Pressure)						

Social History for Adult Patient			
Occupation		Employer	
Do you have children? ☐Yes ☐No	How many?	Female(s)	Male(s)

Tobacco Use ☐No ☐Yes	Daily Weekly Less Former/Year quit:	Chewing Pipe Cigar Cigarette E-Cigarette
Alcohol Use ☐No ☐Yes	Daily Weekly Less Former/Year quit:	Beer Wine Liquor Other:
Exercise Activity	Moderate Vigorous Sedentary Days/Week:	Sleep Pattern: Changes No Changes