PREMIER MEDICAL GROUP
PATIENT MEDICAL HISTORY FORM

DATE:______________________________ DOB:______________________________

PHONE: DAY:______________________________ EVENING:______________________________

PATIENT NAME:____

ADDRESS:____
(STREET) (CITY) (STATE) (ZIP)

BIRTHPLACE:______________________________ ETHNIC BACKGROUND:______________

EMERGENCY CONTACT'S NAME:_________________________ PHONE#:______________

Name of Health Care Proxy/Durable Power of Attorney for Health Care:______________________

Phone#:______________________________

HOUSEHOLD MEMBERS

NAME	AGE	RELATIONSHIP

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SOCIAL HISTORY

Occupation:______________________________ Martial status:______________________________

PERSONAL HEALTH HISTORY: List below any chronic illness (such as diabetes, high blood pressure, etc.) and in date order any hospitalizations and surgeries.

NATURE OF PROBLEM	DATE

MEDICATIONS:

NAME OF MEDICATION	DOSAGE	FREQUENCY

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ALLERGIES/SENSITIVITIES: Are you sensitive to any medication or substance? ___Yes ___No

DRUG	REACTION

PERSONAL HABITS:

Tobacco Use/Exposure:

Do you use any type of tobacco product? ___No___Yes? If yes, for how many years?_______________

What tobacco product do you use? (Check all that apply)
___Cigarettes ___Pipes ___Cigars ___Chewing Tobacco

How often do you use tobacco products?________________
If you do or did smoke, how many packs per day?____________________
If you are a former smoker, when did you quit?_______________________

Substance Use:

Do you consume alcohol? ___No ___Yes If yes, how often?______how much?_________
Do you currently use any illegal drugs? ___No ___Yes,
If yes, what type of drugs do you use and when did you last use?____________________________
Did you use any illegal drugs in the past? ___No ___Yes If yes, how many years did you use?____________
What type of drugs did you use and when did you last take it?______________________________

Other:

Do you exercise regularly? ___No ___Yes, If so, how?______________________________
Have you every had a colonoscopy? ___No ___Yes, if Yes, when______________________________

Safety: Do you regularly use:

Seatbelt	___No	___Yes
Helmet (bicycle or motorcycle)	___No	___Yes
Are there smoke detectors in your home?	___No	___Yes
Do you have guns in your home?	___No	___Yes
Are you or have you been a victim of abuse?	___No	___Yes
Would you like help?	___No	___Yes

GENITO/REPRODUCTIVE

FEMALE

Date of last pap smear______________________________
Age periods began?___________How many days do your periods last?______________________
How often do they occur?_______________When did your last period start?__________________
If your period has stopped, give the year of your last period______________________________
Number of pregnancies_______Numberof births___________Number of miscarrages________________
Type of birth control, if used:______________________________
Do you feel you have a problem with any of the following: (Please specify briefly):
Menopausal symptoms:______________________________
Premenstrual symptoms:______________________________
Sexual function:______________________________

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Male

Do you perform testicular self exam? ______Yes ______No
Have you had a vasectomy? ______Yes ______No
Do you have a problem with any of the following:

Infertility	___No	___Yes	Impotence/sexual function	___Yes	___No
Scrotum or testicles	___No	___Yes	Nightime urination	___Yes	___No
Decrease in stream	___No	___Yes	Change in pattern of urination	___Yes	___No

(Optional) Do you consider yourself: ______Bisexual ______Homosexual

FAMILY HEALTH HISTORY

	Living Age	Deceased Age and cause		Living Age	Deceased Age and Cause
Father			Children 1		
Mother			2		
Spouse			3		
Brother/Sister 1			Maternal Grandmother		
2			Maternal Grandfather		
3			Paternal Grandmother		
4			Paternal Grandfather		

Please write on the appropriate lines which family members have or have had the following medical problems. Please exclude yourself and your spouse, and be sure to list ilnesses affecting your parents grandparents, siblings and children.

Heart Attack/bypass____________________
Other heart disease____________________
High blood pressure____________________
Diabetes____________________
Cancer and type____________________
Thyroid Problem____________________
Sickle Cell ____________________
Asthma ____________________
Psychiatric problem____________________
Overuse of alcohol____________________
Seizures____________________
Migraines____________________
Stroke____________________
Kidney disease____________________
Ulcer____________________
Other ____________________

ADVANCE DIRECTIVES

Are you familiar with advance directives? ______Yes ______No
Have you prepared an advance directive (lving will, health care proxy)? ______Yes ______No
Have you given us a copy of your advance directive to put in your medical records ______Yes ______No
In order for your provider to follow your directive, we encourage you to send us a copy.