CONFIDENTIAL -- MEDICAL HISTORY

The information requested below is strictly confidential, and requested solely for the purpose of allowing your physician to properly assess your and recommend the best possible treatment for any condition or life situation you may face now or in the future.

NAME:____ DATE OF BIRTH: ____________________

LAST NAME First Name Middle Name

Previous or Referring Doctor: ____

SOCIAL HISTORY

Employment: ☐ Retired ☐ Not employed outside home ☐Employed full-time ☐ Employed part-time
☐ Self-employed ☐ Employed full-time + part-time ☐ Employed, 2 or more part-time jobs

Home/Housing: ☐ Live alone ☐ Live with other family members ☐ Live with Friends / Home Sharing ☐ Temporary Housing

Sex as assigned at birth: ☐ Female ☐Male ☐Intersex

Gender Identity: ☐ Female ☐Male ☐ Decline to specify ☐ Gender Fluid ☐ Gender Queer ☐ Other ____________________
☐ Trans [If checked, currently receiving HRT? __Yes __No] *(please specify)*

What are your preferred pronouns? ______________________________________

Orientation: ☐ Decline to specify ☐ Straight/Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Asexual ☐Pansexual ☐ Questioning

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced

Tobacco use? ☐ NO ☐YES What kind?_________________________ How much? _________________________/day

Alcohol use? ☐ None, ever. ☐ Occasionally/Socially ☐ 1 – 3 times weekly ☐ 4 – 7 times weekly ☐ Daily
Preferred beverage: ☐ Beer ☐ Wine ☐ Liquor (Whiskey/Bourbon/Vodka/Gin/Tequila)

☐ I have some concerns about this which I want to discuss with doctor in private.

Recreational Drugs? ☐ NO ☐ YES (Please specify):____

CHILDHOOD ILLNESSES / IMMUNIZATION HISTORY

Please mark the following communicable childhood illnesses you survived in your early life:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio
☐ Other (please specify)

Vaccine	Approximate Date or Year	Location (e.g., Physician name/location; County & State of Health Dept., etc)
☐ Tetanus	__________	____
☐ Hepatitis	__________	____
☐ MMR (Measles/Mumps/Rubella)	__________	____
☐ Pneumonia	__________	____
☐ Chickenpox/Shingles	__________	____

Do you receive an annual influenza vaccine (flu shot)? Date of last vaccine: _______________

(Continued on Reverse)

PERSONAL / FAMILY HISTORY

Have you ever had a blood transfusion? ☐ YES ☐ NO

Do you have or have you had:

Condition			It Is In My Family History	Who had this / How related to you?
Anxiety	☐ **YES**	☐ NO	☐	
Asthma	☐ YES	☐ NO	☐	
Blood clots	☐ YES	☐ NO	☐	
Bronchitis (chronic) / Emphysema / COPD	☐ YES	☐ NO	☐	
Depression	☐ YES	☐ NO	☐	
Diabetes	☐ YES	☐ NO	☐	
Gastric ulcers	☐ YES	☐ NO	☐	
Heart disease	☐ YES	☐ NO	☐	
Heart murmur	☐ YES	☐ NO	☐	
High blood pressure	☐ YES	☐ NO	☐	
Kidney disease	☐ YES	☐ NO	☐	
Liver disease	☐ YES	☐ NO	☐	
Lupus /RA /Auto-immune	☐ YES	☐ NO	☐	
Stroke	☐ YES	☐ NO	☐	
Thyroid disease	☐ YES	☐ NO	☐	
Tuberculosis	☐ YES	☐ NO	☐	
Ulcerative colitis/Crohn's	☐ YES	☐ NO	☐	
Irritable Bowel Syndrome	☐ YES	☐ NO	☐	

›› Please list any other medical problems *not listed above*:

PRIOR HOSPITALIZATIONS / SURGERIES

YEAR	REASON / ILLNESS	HOSPITAL / LOCATION

The HomeTown Doctors, PA. 245 LePhillip Court NE ⧫ 2nd Floor-Suite B Concord, NC 28025
(704) 256-8300 ⧫ thehometowndoctor@gmail.com ⧫ www.thehometowndoctors.com

MEDICATION / FOOD ALLERGIES

IF YOU ARE ALLERGIC TO ANY MEDICATIONS OR FOOD PLEASE LIST HERE:

Name of Drug or Food	What reaction did you / do you generally have?

List below your prescription AND over-the-counter drugs which you currently take. ***Please include vitamins, herbal remedies, inhalers, etc.***

Name of Drug	Who Prescribed for you?
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Do you have any implanted devices or artificial joints? ☐ YES ☐ NO (If yes, please list.)

Do you wear: corrective lens eyeglasses ☐ YES ☐ NO contact lenses ☐ YES ☐ NO hearing aids ☐ YES ☐ NO

I understand the information given above will be scanned/stored electronically in my electronic healthcare records chart for review and reference by my healthcare providers at The Hometown Doctors, P.A. I further understand the information will be maintained as personal health information and afforded all protection pursuant to the General Statues of the State of North Carolina and the US Health Insurance Portability and Accountability Act of 1996 (HIPPA).

____ ______________________

(Signature of Patient / Legal Guardian / Legal Representative) *(Date)*

Update: 03/02/2020