



245 Le Phillip Court NE 2nd Floor, Suite B Concord, NC 28025 704.256.8300

CONFIDENTIAL -- MEDICAL HISTORY

The information requested below is strictly confidential and requested solely for the purpose of allowing your Physician to properly assess 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

What is your primary concern today? _____

SOCIAL HISTORY

Employment: Retired Not employed outside home Employed Self-employed

What do you do for a living? _____

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

Sex: Female Male

Sexual Orientation if you wish to disclose: _____

Marital Status: Single Married Widowed Divorced

Tobacco use: No Yes What kind? _____
How often? _____/day For how many years? _____

Alcohol use: None, ever Occasionally/Socially 1 – 3 times weekly 4 – 7 times weekly
 Daily
Preferred beverage: Beer Wine Liquor

Recreational Drugs: No Yes

Please specify: _____

PERSONAL & FAMILY HISTORY

Have you ever had a blood transfusion? YES NO

Do you have or have you had:

			It Is in My Family History	Who had this / How related to you?
Anxiety	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Blood clots	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Bronchitis (chronic) /Emphysema/COPD	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Gastric ulcers	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Liver disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Lupus/RA/Auto-immune	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Muscle/Back problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Skin issues	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Ulcerative colitis/Crohn's	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____
Irritable Bowel Syndrome	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/>	_____

>> Please list any other medical problems not listed above:

Please list ALL prescription AND over-the-counter drugs which you currently take. Include vitamins, supplements, herbal remedies, inhalers, etc. Please note dosage and directions.

Name of Medication, dosage and directions	Name of Medication, dosage and directions

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 (EHR) chart for review and reference by my healthcare providers at The Hometown Doctors, P.A. I further understand the information will be maintained as Protected Health Information (PHI) and afforded all protection pursuant to the General Statutes of the State of North Carolina and the US Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient / Legal Guardian / Legal Representative

Date