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: ____

Patient Name: ____________________________________ DOB: _________________

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	☐	________________
Cancer	☐ 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	☐	________________
High Cholesterol	☐ YES	☐ NO	☐	________________
Kidney disease	☐ YES	☐ NO	☐	________________
Liver disease	☐ YES	☐ NO	☐	________________
Lupus/RA/Auto-immune	☐ YES	☐ NO	☐	________________
Migraines	☐ YES	☐ NO	☐	________________
Muscle/Back problems	☐ YES	☐ NO	☐	________________
Skin issues	☐ 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:

Patient Name: ___________________________________ DOB: ________________

CHILDHOOD ILLNESSES & IMMUNIZATION HISTORY

Vaccine/Approximate Year	Vaccine/Approximate Year
☐ Tetanus	☐ Influenza (flu)
☐ Hepatitis B	☐ COVID Vaccine/1st dose
☐ Pneumonia	☐ COVID Vaccine/2nd dose
☐ Chickenpox/Shingles	☐ COVID Vaccine/booster

PRIOR HOSPITALIZATIONS & SURGERIES ☐ None

Year	Reason/Illness

MEDICATION & FOOD ALLERGIES ☐ No known food or drug allergies

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

Patient Name: ___________________________________ DOB: ________________

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).

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Signature of Patient / Legal Guardian / Legal Representative Date

Printed Name: ____