THE HOMETOWN DOCTORS, P.A.
DIRECT PRIMARY CARE
EST 2018

1925 Concord Lake Road Kannapolis, NC 28083-6448 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:

			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 <u>not listed above</u>:

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).

_____

Signature of Patient / Legal Guardian / Legal Representative Date

Printed Name: _____