

Covenant Medical Center, P.C.

Patient History Form

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? Yes No If yes, date & reason: _____

Have you ever been tested for hepatitis A, B or C? Yes No Which Virus? _____

Have you been vaccinated for hepatitis B? Yes No When? _____

Have you been vaccinated for hepatitis A? Yes No When? _____

Last (TB) Tuberculosis Screening? _____ Result of screening? Positive Negative

If positive, date of last chest x-ray? _____ Result of chest x-ray? Positive Negative

Which of the following conditions are you currently being treated or have been treated for?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart Disease/
Murmur/ Angina | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Eye disorder/ Glaucoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney/ Bladder
problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver problems/ Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Lung problems/ cough |
| <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia or blood | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Thyroid problems |

Please list any current or past medical conditions not listed above

Please list your past surgeries and date of procedure

Please list any previous medications:

Please list any current medications:

Allergies

Are you allergic to penicillin or any other drugs? _____

Any non/drug, latex or food allergies? _____

Social and Preventive History

Do you smoke or chew tobacco? Yes No If no, have you in the past? Yes No

How many packs per day? _____

Do you drink alcohol, beer or wine? Yes No If no, have you in the past? Yes No

How many drinks per week? _____

Family History

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List serious illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Females Only: Gynecological History

How many times have you been pregnant? _____

No. of vaginal birth: _____ C-section: _____ Miscarriage: _____ Termination: _____

Have you had an abnormal Pap Smear? _____ Diagnosis: _____

Date of last mammogram: _____ Results: _____

Have you ever had a breast biopsy? _____ Results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Signature: _____ **Date:** _____