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?

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

	Living		Age (or age at death)	List serious illnesses
Mother	□Yes	□No	_____	_____
Father	□Yes	□No	_____	_____
Sisters	□Yes	□No	_____	_____
Brothers	□Yes	□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:** _____