Primary Care, PLLC | Primary Care GYN, PLLC | St. Croix Diagnostics, LLC

Medical History Form

Today's Date_____

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY:

Diabetes ____ Asthma ____ GERD ____ Arthritis ____
Hypertension ____ Liver Disease ____ Cancer ____ COPD ____
Cholesterol ____ Osteoporosis ____ Depression ____ Irregular Menses ____
Other: _____

PAST SURGICAL HISTORY INCLUDING DATE OF SURGERY:

Appendectomy ____/_____ Colostomy ____/_____ Prostate Biopsy ____/_____
Pacemaker ____/_____ Thyroidectomy ____/_____ Vasectomy ____/_____
Hernia Repair ____/_____ Cataract Extraction ____/_____ Tonsillectomy ____/_____
Other: _____

OB/GYN History:

Last Menstrual Period: _____ Last Pap Smear: _____
Last Mammogram: _____ Last Ultrasound: _____
Number of Pregnancies: _____ Number of Live Births: _____
Number of C-Sections: _____ Other: _____

SOCIAL HISTORY:

- Do you Smoke? Yes No Former Smoker: Yes No Year Quit: _____
- Number of Packs per day: _____ Number of years you smoked: _____
- Do you drink alcohol? Yes No Occasionally/Socially/Daily/Weekly Amount _____
- Are you a former drinker? Yes No Year Quit: _____
- Do you drink Caffeine? Yes No Type? Coffee/Energy Drink/Soda
- Daily amount: _____

FAMILY MEDICAL HISTORY:

Mother: _____
Father: _____
Siblings: _____

ALLERGIES: ***(Please List all Medications, Food and or any Environmental allergies)***

_____

_____

MEDICATIONS: (Name and Dosage)

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

PREFERRED PHARMACY: _____

***My signature authorizes consent for medical diagnosis and treatment to be rendered by Primary Care, PLLC personnel and its locations.**

***Treatment of a Minor must be authorized with signature by a Parent or Guardian of Minor.** _____

_____

***Signature of patient, parent, guardian, or personal representative**