Flora Medical Clinic, PLLC.

PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Do not answer any question you are uncomfortable with. Approximate any details you cannot remember precisely. Add any notes you think important. ALL QUESTIONS ARE OPTIONAL AND DATA WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1	_____	_____
2	_____	_____
3	_____	_____

FAVORITE PHARMACY

_____

MEDICATIONS

Please enter all the medications you are taking, ONLY if you do not have a printed list or your bottles with you.

Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐	Flu Shot	Date: _____	☐	Meningococcus	Date: _____
☐	Gardasil/HPV	Date: _____	☐	Pneumonia	Date: _____
☐	Hepatitis A	Date: _____	☐	Tdap (Td/Tetanus/Tdap)	Date: _____
☐	Hepatitis B	Date: _____	☐	Zostavax (Shingles)	Date: _____
☐		Date: _____	☐		Date: _____

PAST SURGICAL HISTORY

	SURGERY	YEAR
1		
2		
3		

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder/Urinary problems
- ☐ Blood Clots(DVT/PE)
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Colonoscopy
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression/Anxiety
- ☐ Diabetes -insulin
- ☐ Diabetes- Non insulin
- ☐ Ear or Hearing Problems
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headache/Migraines
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hospitalization
- ☐ Injuries/Accidents
- ☐ Irregular heart beat/arrhythmia
- ☐ Kidney disease/stones
- ☐ Leukemia/other blood disorder
- ☐ Liver Disease
- ☐ Memory problem/dementia
- ☐ Mental Illness
- ☐ Obesity
- ☐ Osteoporosis
- ☐ GI/bowel problems
- ☐ Pneumonia
- ☐ Polyps in colon
- ☐ Prostate problems
- ☐ Reflux/GERD
- ☐ Seizures/Epilepsy
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid problem
- ☐ Tuberculosis
- ☐ Vitamin D Def
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HEALTH HISTORY

List which family member has had the following conditions from amongst your Father, Mother, Brother, Sister or Grandparent

CONDITION	FAMILY MEMBER (F/M/B/S/G)	CONDITION	FAMILY MEMBER (F/M/B/S/G)
☐ None current		☐ Alcoholism	
☐ Unknown		☐ Cancer	
☐ Adopted		☐ Osteoporosis	
☐ Diabetes		☐ Kidney disease	
☐ Hypercholesterolemia		☐ Arthritis	
☐ Hypertension		☐ Chronic depression	
☐ Heart disease		☐ Alzheimer's	
☐ Paralytic stroke		☐ Other	

GYNECOLOGICAL HISTORY

Latest Bone Density	Date: _____	Colposcopy	Date: _____
Latest Mammogram	Date: _____	Menses Monthly	☐ Yes ☐ No
Latest PAP Smear	Date: _____	Duration of flow (days)	_____
Abnormal PAP ☐ Yes ☐ No		LMP ☐ Unknown	☐ Approximate ☐ Definite
Current birth control method	_____	# Pregnancies _____	# Births _____
Age of menopause (if applicable)	_____	# Miscarriages _____	# Abortions _____
Hormone Replacement Therapy	☐ Yes ☐ No	# C-sections _____	

SOCIAL HISTORY

Occupation _____

Children _____

Hobbies/Activities

_____

Education
☐ Less than 8th grade
☐ High school
☐ 2 / 4 year college
☐ Post Grad

Marital status
☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Domestic Partner

Exercise level
☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Live alone or with others
☐ With others
☐ Alone

Sexually active
☐ Yes
☐ No

Do you cook your meals
☐ Yes
☐ No

Diet
☐ Regular
☐ Vegetarian ☐ Vegan
☐ Gluten Free
☐ Specific
☐ Carbohydrate
☐ Cardiac ☐ Diabetic

Alcohol
☐ No
☐ Yes
drinks / week _____

Soda intake
☐ No
☐ Yes
cans / week _____

Sexual orientation
☐ Heterosexual
☐ Homosexual
☐ Bisexual

Do you have pets
☐ Yes
☐ No

Smoking / Tobacco Status
☐ Never
☐ Former
☐ Current
taken per day ____
Years of habit ____

Passive smoke exposure
☐ No
☐ Yes

Recreational drugs
☐ No
☐ Yes
Please list: _____

ADVANCE DIRECTIVE

Do you have advance directives for medical decisions (Living will)? ☐ Yes ☐ No

_____ _____

Patient, Parent, Guardian or Caregiver signature Date