CLARK MEDICAL GROUP

Norton Healthcare and LifePoint Health

Date: _____

FAMILY AND PERSONAL HEALTH HISTORY

Patient's Full Name: _____ DOB: _____

Pharmacy Name/Address: _____

Previous Primary Care Physician: _____ Referred by: _____

Have you been seen in our office before: Yes No

OTHER PHYSICIANS THAT PARTICIPATE IN YOUR HEALTHCARE:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATION/SUBSTANCE ALLERGIES: (Please list reactions)

1. _____
2. _____
3. _____

MEDICATIONS: (Please list name, dose, and frequency)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ADVANCED DIRECTIVES:

Do you have a Living Will? (Please provide copy) [ ] Yes [ ] No

Do you have a Power of Attorney? (Please provide copy) [ ] Yes [ ] No

What is your Code Status? (Example: DNR- Do Not Resuscitate) _____

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Alcohol Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Tobacco Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Illicit Drug Use: [ ] None [ ] Marijuana [ ] Cocaine [ ] Crack [ ] Meth [ ] Other _____

Caffeine Use: [ ] Soda [ ] Coffee [ ] Tea # per day_____

Do you exercise regularly: [ ] Yes [ ] No How many times per week? _____ How long? _____

Activities:_____

Religion: _____

Occupation:_____

With whom do you live?_____

Patient's Name: _____

DOB: _____

PERSONAL HISTORY:

[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Heart Attack
[ ] Yes [ ] No Heart Disease
[ ] Yes [ ] No High Blood Pressure
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Depression, Anxiety, Bi-Polar
[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Cancer (Type) _____
[ ] Yes [ ] No Other _____

# of Pregancies ____ # of Live Births ____ Miscarriages ____ Abortions ____

C-Sections (# and Year) _____

PREVENTIVE HEALTH: (Please list dates and results)

Cholesterol _____ Dexa Scan _____

Mammogram _____ Pap Smear _____

Colonoscopy _____ PSA _____

IMMUNIZATIONS: (Please list dates)

Pneumonia _____ Hepatitis A _____

Tetanus _____ Hepatitis B _____

Measles _____ Tuberculosis _____

Influenza _____ Shingles _____

Other _____ Other _____

FAMILY HISTORY: (Please check all that apply)

Illness/Condition	Father	Mother	Sibling	Grandparents (Maternal/Paternal)
Diabetes				
Heart Attack				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Disease				
Depression/Anxiety/Bi-Polar				
Stroke				
Osteoporosis				
Cancer				
Other				

RECENT HOSPITALIZATIONS: (Year, Illness, Surgeries)

1. _____
2. _____
3. _____
4. _____
5. _____