HVMG Primary Care – Ellwood City
Franklin Plaza, 273 Rt. 288, Ellwood City, PA 16117

MEDICAL HISTORY **Today's Date:**

Name: _____ Age: _____ Birthdate: _____

List of significant medical problems, both past and current:
[ ] None

_____

_____

List of hospitalizations and approximate dates:
[ ] None

_____

_____

List of surgical procedures and approximate dates:
[ ] None

_____

_____

List current medications with dosage and frequency (please include over-the-counter and herbals):
[ ] None

_____

_____

List current allergies to medications and reactions:
[ ] None Allergic to latex: [ ] Yes [ ] No Allergic to contrast dye: [ ] Yes [ ] No

_____

_____

HEALTH HABITS

Do you use tobacco [ ] Yes [ ] No
What type and how much? _____If you quit, what year?_____
Do you drink alcohol [ ] Yes [ ] No How much per week?_____
Do you drink caffeine [ ] Yes [ ] No How much per day?_____
Do you use recreational drugs [ ] Yes [ ] No What type?_____ How often?_____
Do you exercise regularly [ ] Yes [ ] No How often? _____
Do you always wear a seatbelt [ ] Yes [ ] No

SOCIAL HISTORY

Current school or occupation_____
Marital status: [ ] Single [ ] Married [ ] Domestic Partner [ ] Divorced [ ] Separated [ ] Widowed
Who lives in your household?_____

REVIEW OF SYMPTOMS **(circle all that apply)**

Weight gain/loss	Heartburn	Dizziness
High blood pressure	Change in bowel habits	Fainting/passing out
Chest pain	Blood in stool	Memory problems
Palpitations	Urinary	Depression
Shortness of breath	incontinence/leaking urine	Anxiety
Wheezing/asthma	Weak urinary stream	Rash
Abdominal pain	Blood in urine	Seasonal allergies

Women:

Date of last menstrual period: _____
Last PAP smear: _____Have you ever have an abnormal PAP [ ] Yes [ ] No
Last mammogram: _____
Birth Control: [ ] Yes [ ] No Type: _____

******PLEASE COMPLETE THE BACK PAGE******

Men:

Last prostate (rectal) exam: _____

IMMUNIZATION and TEST HISTORY

Have you had?

YES	NO		Year
[ ]	[ ]	Influenza Vaccine	
[ ]	[ ]	Tetanus Vaccine within 10 Years	
[ ]	[ ]	Pneumonia Vaccine	
[ ]	[ ]	Chicken Pox (illness/shot)	
[ ]	[ ]	Colonoscopy	
[ ]	[ ]	Stress test	
[ ]	[ ]	Heart Catheterization	

FAMILY HISTORY

	Male or Female	Living Age	Deceased Age	Medical problems or cause of death
Parents				
Siblings				
Children				

Do any of your close relatives have (circle all that apply):

Hypertension (high blood pressure)
Heart disease
Atrial fibrillation (irregular heart beat)
Congestive heart failure
Stroke
Blood clots
Anemia
Asthma
COPD/Emphysema
Crohns disease/Ulcerative colitis
Celiac disease (wheat allergy)
Diabetes
Thyroid problems
Osteoporosis
Seizures
Cancer (what type? _____)

ADVANCED DIRECTIVES

Do you have an Advanced Directive or Living Will (stating your wishes if you become terminally ill)? **[ ] Yes [ ] No**
If so, please bring it to office so we can place a copy into your chart.
If not, would you like information about it? **[ ] Yes [ ] No**