Premier MEDICAL GROUP

Complete Medical History

Today's Date: _____

Patient Name: _____ DOB: _____ PCP: _____

Are or could you be pregnant? ☐ Yes ☐ No Comments: _____

Do you have: Advance Directives: ☐ Yes ☐ No Power of Attorney: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No Personal Representative (HIPAA): ☐ Yes ☐ No

Past Medical History:

			Comments:				Comments:
Diabetes	☐ Yes	☐ No		Hepatitis (Any type)	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No		HIV/AIDS	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No		Gout	☐ Yes	☐ No	
Stomach Ulcers	☐ Yes	☐ No		Rheumatoid Arthritis	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No		Other:			
Cancer (Any type)	☐ Yes	☐ No					

Prior Surgery (List type and date):

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medication Allergies: (Include surgical soaps, tape, latex or idodine)

_____

_____

_____

_____

Medications: (List the name and dose)

_____ _____

_____ _____

_____ _____

_____ _____

What Pharmacy Do You Use? _____ **Where is it?** _____

Social History:

Smoker Status: ☐ Current every day smoker ☐ Current some days smoker ☐ Former smoker ☐ Never smoked

Tobacco Use: ***Use Tobacco***: ☐ Current ☐ Former ☐ Never

Type of Tobacco: ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Chewing ☐ Other: _____

Ever tried to quit: ☐ No ☐ Yes Year Quit: _____

Passive Smoke Exposure: ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No How often (frequency of use): _____

Other drugs ☐ Yes ☐ No How often (frequency of use): _____

(recreational, not prescribed to you)

Review of Symptoms - Do or have you experience(d) any of the following:

Fever	☐ Yes	☐ No	Painful Urination	☐ Yes	☐ No	Numbness and/or burning	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Seasonal allergies	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No	Blurred vision	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Muscle pain	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Stomach Pain	☐ Yes	☐ No	Rash	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No

Your Family Medical History:

			Comments:
Diabetes	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
Cancer (Any type)	☐ Yes	☐ No	
Rheumatoid Arthritis	☐ Yes	☐ No	

For Office Use Only:

PFSH and ROSH Updated

Date/Initials	Date/Initials	Date/Initials