Premier
MEDICAL GROUP

PRIMARY CARE FAMILY& SOCIAL HISTORY

Please check all other Premier locations where you are also a patient.	☐ St. B	☐ Richview	☐ OBGYN
	☐ Governor's Sq	☐ Eye Center	
	☐ ENT	☐ Imaging	

Patient: ______________________________ **Date of Birth**: ______________________

Primary Language Spoken:______________________

Employed: ☐ Yes ☐ No

Please Complete This Section

Employer	Occupation	Physical Restrictions	Employment Status	Retire Date

Occupational Hazards (list): ______________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Do You have Children: ☐ Yes ☐ No

Please list others who you consider to be your support network (friends, family members, co-workers, etc.):

____

Tobacco Use: ☐ Yes ☐ No ☐ Previous Smoker. If Yes, have you tried to quit: ☐ Yes ☐ No. Other smokers in home: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Previous Use. If Yes, how much: __________ and how often: ______________

Advance Directives: ☐ None ☐ Do Not Resuscitate (DNR) ☐ Living Will ☐ Durable Power of Attorney (POA)

Your Past Medical History: **Have you been diagnosed with any of the following?**

Condition		Condition	
Allergies	☐ Yes ☐ No	Gastroesophageal Reflux Disease (GERD)	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Angina	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Irritable Bowel Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Benign Prostate Hypertrophy	☐ Yes ☐ No	Myocardial Infarction (Heart Attack)	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Emphysema (COPD)	☐ Yes ☐ No	Peptic Ulcer Disease	☐ Yes ☐ No
Crohn's Disease	☐ Yes ☐ No	Renal Disease (Kidney Disease)	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stroke (CVA)	☐ Yes ☐ No
Gallbladder Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
		OTHER: ______________________	

Your Past Surgery History: **Have you had any of the following surgical procedures?**

Procedure	Yes / No	Year	Procedure	Yes / No	Year
Angioplasty (heart balloon procedure)	☐ Yes ☐ No	________	Pacemaker	☐ Yes ☐ No	________
Angioplasty w/Stent	☐ Yes ☐ No	________	Small Bowel Resection	☐ Yes ☐ No	________
Appendectomy	☐ Yes ☐ No	________	Thyroidectomy	☐ Yes ☐ No	________
Arthroscopy on Knee (Scope)	☐ Yes ☐ No	________	Tonsillectomy	☐ Yes ☐ No	________
Back Surgery	☐ Yes ☐ No	________	**GENDER SPECIFIC (Female):**		________
Coronary Artery Bypass Graft (CABG)	☐ Yes ☐ No	________	Augmentation (Breast)	☐ Yes ☐ No	________
Carpal Tunnel Release	☐ Yes ☐ No	________	Bilateral Tubal Ligation	☐ Yes ☐ No	________
Cataract Removal	☐ Yes ☐ No	________	Breast Biopsy	☐ Yes ☐ No	________
Cholecystectomy (Gall Bladder removed)	☐ Yes ☐ No	________	Cesarean Section	☐ Yes ☐ No	________
Colon Resection	☐ Yes ☐ No	________	D and C	☐ Yes ☐ No	________
Colostomy	☐ Yes ☐ No	________	Hysterectomy	☐ Yes ☐ No	________
Gastric Bypass	☐ Yes ☐ No	________	Mastectomy	☐ Yes ☐ No	________
Hernia Repair	☐ Yes ☐ No	________	Benign Uterine Tumor Removed	☐ Yes ☐ No	________
Hip Replacement	☐ Yes ☐ No	________	Reduction (Breast)	☐ Yes ☐ No	________
Knee Replacement	☐ Yes ☐ No	________	Abdominal Hysterectomy	☐ Yes ☐ No	________
LASIK	☐ Yes ☐ No	________	Ovaries Removed	☐ Yes ☐ No	
Liver Biopsy	☐ Yes ☐ No	________	Vaginal Hysterectomy	☐ Yes ☐ No	________
			Ovaries Removed	☐ Yes ☐ No	
Open Reduction Internal Fixation (ORIF)	☐ Yes ☐ No	________			

OTHER: ____

Family History: Please let us know about your family's (Blood Relatives Only: Parents, Brothers,Sisters, Children) health. Please answer these questions as completely as you can.

Condition	Yes / No	Age of Onset or Death	Condition	Yes / No	Age of Onset or Death
ADD/ADHD	☐ Yes ☐ No		Hearing Problems	☐ Yes ☐ No	
Alcoholism	☐ Yes ☐ No	________	High Cholesterol	☐ Yes ☐ No	________
Allergies	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	________
Alzheimer's Disease	☐ Yes ☐ No	________	Irritable Bowel Disease	☐ Yes ☐ No	________
Asthma	☐ Yes ☐ No		Learning Disability	☐ Yes ☐ No	
Blood Disease	☐ Yes ☐ No	________	Mental Illness	☐ Yes ☐ No	________
Coronary Artery Disease (heart)	☐ Yes ☐ No	________	Migraines	☐ Yes ☐ No	
Crohn's Disease	☐ Yes ☐ No	________	Obesity	☐ Yes ☐ No	________
Cancer	☐ Yes ☐ No	________	Osteoarthritis	☐ Yes ☐ No	________
Cerebrovascular Accident (stroke)	☐ Yes ☐ No	________	Osteoporosis (brittle bones)	☐ Yes ☐ No	________
Depression	☐ Yes ☐ No		Polyps in colon	☐ Yes ☐ No	________
Developmental Delay	☐ Yes ☐ No		Vascular Disease	☐ Yes ☐ No	________
Diabetes	☐ Yes ☐ No	________	Renal Disease (Kidney Disease)	☐ Yes ☐ No	________
Eczema	☐ Yes ☐ No		Seizure Disorder	☐ Yes ☐ No	________

OTHER: ____

Patient Signature: ______________________________ **Date**:______________