Medical History

[Please Print]

GREATWOOD PRIMARY AND PREVENTIVE CARE

PATIENT NAME:_____ **DATE:**_____

ALLERGIES

☐ Check here if have No Known Allergies

Please list any known allergies:

_____

_____

PLEASE SELECT ALL THAT APPLIES TO YOU

☐ Abdominal Pain	☐ Congestive Heart Failure	☐ Fatigue	☐ Obesity	☐ Ulcerative Colitis
☐ Arthritis	☐ Coronary Artery Disease	☐ Fever	☐ Osteoporosis	☐ Urinary Tract Infection
☐ Asthma	☐ Coughing	☐ GERD	☐ Renal Failure	☐ Vomiting
☐ Bipolar	☐ Depression	☐ High Blood Pressure	☐ Shortness of Breath	☐ Weakness
☐ Chest Pain	☐ Diabetes Mellitus	☐ High Cholesterol	☐ Sleep Apnea	☐ Weight Gain
☐ Cirrhosis of Liver	☐ Diarrhea	☐ Nausea	☐ Thyroid Problems	☐ Weight Loss

☐ Other: _____

_____

FAMILY HISTORY

Father: ☐ Living - Age: _____ ☐ Deceased - Age at Death: _____ (Cause) _____

Mother: ☐ Living - Age: _____ ☐ Deceased - Age at Death: _____ (Cause) _____

Siblings: Number Living: _____ Number Deceased: _____ (Cause) _____

Please list other health problems within your family.

Family Member	Health Problem	Family Member	Health Problem
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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GP PC
GREATWOOD PRIMARY AND PREVENTIVE CARE

PATIENT NAME:_____ **DATE:**_____

SURGERIES / PROCEDURES

Please list any past surgeries / procedures:

Surgery / Procedure	When	Where
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Smoke? ☐ Yes ☐ No If yes, how much? # of packs / day: _____ # of years: _____ When did you stop smoking? _____

Alcohol? ☐ Yes ☐ No If yes, how much? _____ When did you quit drinking alcohol? _____

Exercise? ☐ Yes ☐ No If yes, what type of exercise and how frequently? _____

CURRENT MEDICATIONS

Name of Drug	Dose	Quantity	# of times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide information about the Pharmacy you use.

Name: _____ Location _____ Phone #: _____