OakLeaf CLINICS
PINE GROVE FAMILY MEDICINE

PATIENT INFORMATION/ Health History Form

Patient's Legal Name (Last)_____(First)_____(MI)_____

Preferred First Name: _____ Maiden Name/Previous Names: _____

SSN_____ Birthdate_____ Ø Male Ø Female

Address _____City_____ State ____ Zip_____

Home Phone#_____ Cell Phone#_____ Work Phone#_____

Patient's Employer_____ Occupation: _____

Emergency Contact Name: _____ Phone Number _____

Email Address: _____ Would you like information on the patient portal? Ø Yes Ø No

Appointment Reminders: Ø Telephone Call Ø Text Message *(Message & data rates may apply)* Ø Patient Portal/Email

Please Check all that apply: Ø Minor Ø Single Ø Married Ø Divorced Ø Widowed Ø Separated

Race: Ø White Ø Asian Ø Native Hawaiian Ø Other Pacific Islander Ø African American Ø American Indian Ø Alaska Native

Language: Ø English Ø Spanish Ø Hmong Ø Other_____ **Ethnicity**: Ø Not Hispanic/Latino Ø Hispanic/Latino

Legal Guardian/Parent's Name (If applicable) _____ Phone # _____

Legal Guardian/Parent's Name (If applicable) _____ Phone # _____

Are you a Student? Name of school/college: _____

Who is your Primary Care Provider? _____Whom may we thank for referring you? _____

FAMILY INFORMATION: Name and Age

Spouse:

Children:

INSURANCE INFORMATION/RESPONSIBLE PARTY: *Required, unless you are self-pay*

Primary Insurance _____ID #_____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

Secondary Insurance _____ID # _____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

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PAST MEDICAL HISTORY: *Please check all that apply*

	Arthritis		Kidney Disease/Problems		Anemia
	Diabetes		Radiation Therapy		Chemotherapy
	Blood Clots		Rheumatic Fever		Jaundice (Yellowing of Skin)
	Heart Attack/Chest Pain		Tuberculosis		Sinus Problems
	Stroke		Bleeding Tendency		Pneumonia
	Transfusions		Bronchitis		Asthma/Wheezing
	Thyroid Disease/Goiter		High Blood Pressure		Emphysema
	COPD		Congestive Heart Disease		Nervous Breakdown
	Chicken Pox or Immunization		High Cholesterol		Depression
	Cancer		Valve Replacement		Joint Replacement
	Heart Murmur		Difficulty Sleeping		Headaches
	Excessive Fatigue		Weight Loss/Gain		Moles that Have Changed
	Heartburn		Constipation		Diarrhea
	Black Tarry Stools		Recurrent Stomach Pain		Bladder Control/Leak
	Vaginal Discharge (Itching/Burning)		Difficulty Swallowing		Sores in the Mouth
	Long-Term Back Pain		Swollen Painful Joints		Swelling of Feet/Ankles

Please describe any other medical problems not listed above:

_____

_____

_____

PREVIOUS HOSPITALIZATIONS	**Year**	**PREVIOUS SURGERIES**	**Year**

FAMILY MEDICAL HISTORY

Family Member	Age	Living	Major Illness
Father			
Mother			
Brothers			
Sisters			

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IMMEDIATE FAMILY WITH ANY OF THE FOLLOWING:

	Cancer		Alcoholism
	Goiters		Allergy
	Kidney Disease		Bleeding Tendency
	Tuberculosis		Asthma

ALLERGIES	**REACTION**
Non-Drug	
Drug	
Food/Seafood	

Please list all current medications and supplements:

MEDICATION NAME	**DOSE**	**FREQUENCY**

PROCEDURES	**MONTH/YEAR**
Colonoscopy	
Mammogram	
PAP	
Bone Density	
PSA	

IMMUNIZATION	**YEAR**
Tetanus	
Flu Vaccine	
Pneumonia	
HPV	
Hepatitis B	

Check all that apply:

	Illegal Drugs		Regularly Exercise		Special Diet
	Good Support Group		Wear Seat Belts/Helmets		Alcohol Use
	Caffeine Consumption		Smoker		Chewing Tobacco

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WOMEN'S HEALTH ONLY:

Medical Problems	No	Yes	Have Now	In the Past
Abnormal Pap Smear				
Procedures on your cervix				
Abnormal Bleeding				
Breast, uterine, ovarian or colon cancer				
Surgery on uterus or C-Section				
Breast cysts, lumps, biopsies				
Nipple discharge				
Fibroids				
Night sweats, hot flashes				
Pain with intercourse				
Recurrent vaginal infections				
Unable to get pregnant after trying				
Uterine abnormalities				
Verbal, physical or sexual abuse				
History of Sexually Transmitted Diseases:				
Chlamydia				
Warts (HPV)				
Gonorrhea				
Syphilis				
Herpes				
HIV/AIDS				

Please answer the following:

What was the first day of your last menstrual period?	
How old were you when you had your first period?	
How often do you get your period?	
How many days do you menstruate?	
Are your periods heavy or painful?	
When was your last pap smear?	
How many times have you been pregnant?	
How many children do you have?	
How many vaginal deliveries?	
How many C-Sections?	
How many miscarriages?	
How many elective abortions?	
How do you currently prevent pregnancy?	
How long have you been with your current partner?	