Cornerstone Family Practice PATIENT HISTORY FORM

Name:_____Date of Birth:_____Date:_____

Social History

Marital Status: Single Married Divorced Widow Other **Occupation:**_____Retired From:_____

Do you have a Living Will/Durable Power of Attorney? Yes No ☐ I desire more information

Are you currently using or participating in the following:

Alcohol	*Yes*	*No*	Type:	How Often/Amount:
Caffeine (Coffee, tea, soda)	*Yes*	*No*	Type:	How Often/Amount:
Illicit/Recreational Drugs	*Yes*	*No*	Type:	How Often/Amount:
Tobacco	*Yes*	*No*	Type:	How Often/Amount:
Never Smoked	*Yes*	*No*	Quit: (Year)	E Cigaretttes/Vapes:
Exercise	*Yes*	*No*	Type:	How Often/Amount:
Diet--Well balanced or Poor			Any Dietary Restrictions:	
History of Abuse	*Yes*	*No*	Type:	Currently Abused: Yes or No
Military History	*Yes*	*No*	When:	Where:
Active in Spiritual Interests	*Yes*	*No*	(Church-religious)	
Sexually Active	*Yes*	*No*		

Personal Medical History (please check all that apply)

___Anemia	___Epilepsy/Seizure	___Migraines
___Asthma	___Heart Disease	___Osteoporosis
___Arthritis	___ Heart Failure-Congestive	___STD History
___Bleeding Disorder	___ High Cholesterol	___Stroke
___Cancer	___High Blood Pressure	___Thyroid Disease
___COPD/Emphysema	___Kidney Disease	Other_____
___Depression/Anxiety	___Liver Disease	Other_____

Any problems or concerns with:

	Surgeries or Hospitalizations	
Fatigue, change in weight or energy level? Yes/No	Date	Type
Easy bruising, bleeding or anemia? Yes/No		
Changes in vision or hearing? Allergies/congestion? Yes/No		
Shortness of breath, cough, wheezing, lung issues? Yes/No		
Chest pain, palpitations, angina, heart problems? Yes/No		
Stomach upset, heartburn, change in bowel habits? Yes/No		
Difficulty emptying bladder, urinary frequency? Yes/No		
Aches or pain in arms, legs, trunk, neck? Yes/No		
Changes in your skin, irregular spots? Yes/No		
Dizziness, headaches, numbness or tingling? Yes/No		
Mood swings, depression, anxiety, anger, insomnia? Yes/No		
Problems with sexual functioning, pain with sex, loss of interest? Yes/No		
Problems with snoring or sleep apnea? Yes/No		
Latex or Iodine allergy? Yes/No		

Medical procedures in the past? Cardiac Stress Test Cardiac Cath EGD Colonoscopy Mammogram

Immunizations: Date of last Tetanus:_____Pneumococcal vaccine:_____

If Applicable:

Last Menstrual period:_____ Number of Pregnancies_____Number of Live Births_____

Cornerstone Family Practice PATIENT HISTORY FORM-PG. 2

Name:_____ Date of Birth:_____Date:_____

Please list in order your preference to be contacted: _____Home Phone Number: _____

(List in order of 1, 2, 3) _____ Cell Number: _____

_____ Text: _____

Current Medication, Vitamins and over the counter supplements List

Medication	Dose Amount	How Often Taken

Medication Allergies: Yes or No (if yes, list below)	Reaction

Family History

Please list below any of the following major illnesses in your family history: Diabetes, Heart Disease, Cancer, Bleeding Disorder, Stroke, Hypertension, Etc.

Relative	Medical Illness	Alive/Age at Death
Father		
Mother		
Brother		
Sister		
Maternal Grandfather		
Maternal Grandmother		
Paternal Grandfather		
Paternal Grandmother		
Other		

Please list below any changes in surgeries, hospitalizations, new medical problems or medications since your last visit: