Annual Patient History, Age 18 & Over

Patient Name (Print) _____DOB _____ Occupation_____

Marital Status _____Gender M ☐ F☐

Any changes to Family History, please explain					
M = Mother F = Father GP = Grandparents S = Sibling					
Description	**M**	**F**	**GP**	**S**	**Age of Onset/Comments**

PERSONAL HISTORY

Any new medications from another provider:_____

Hospitalizations, Cause & Date(s):_____

Other Health Problems: _____

Surgeries, Type & Date(s): _____

HEALTH CARE MAINTENANCE: Please fill out if you had any of these in the past year by another provider:

For everyone:

Physical Exam ☐Yes ☐No **Stool for Blood** ☐Yes ☐No **Colonoscopy** ☐Yes ☐No
Cholesterol Test ☐Yes ☐No **Eye exam/Vision test** ☐Yes ☐No **Hearing test** ☐Yes ☐No **Dental exam** ☐Yes ☐No

For women:

Do you do monthly self-breast exams? ☐Yes ☐No **Mammogram?** ☐Yes ☐No
Breast exam by provider ☐Yes ☐No **PAP Smear/Pelvic exam?** ☐Yes ☐NO

For men:

Do you do monthly self-testicle exams? ☐Yes ☐No **Prostate/Testicle exam by provider?** ☐Yes ☐No
PSA Blood test ☐Yes ☐No

Do you have a gun? ☐Yes ☐No Do you practice gun safety? ☐Yes ☐No

Any history or abuse? ☐Mental ☐Physical ☐Sexual ☐Emotional

Review of Systems: Has there been any changes in or new problems which are recurring chronic conditions? Explain below.

Please explain: _____

Patient signature: _____ Date:_____Provider's signature:_____Date:_____