STAT WELLNESS
PRIMARY HEALTHCARE

# STAT Wellness Center, PLLC
# Medical History

Patient Name: ________________________________________ Date of Birth: _________________
Reason for today's visit: _____________________________________________________________
Pharmacy 1) _____________________________ Pharmacy 2) _______________________________

## Past Medical History (Please circle if you ever had any of the following)

| | | | |
|---|---|---|---|
| High Blood Pressure | yes | no | If yes, year of diagnosis _____________ |
| High Cholesterol | yes | no | If yes, year of diagnosis _____________ |
| Diabetes | yes | no | If yes, year of diagnosis _____________ |
| Hypo/Hyper Thyroid | yes | no | If yes, year of diagnosis _____________ |
| COPD/Emphysema/Asthma | yes | no | If yes, year of diagnosis _____________ |
| GERD | yes | no | If yes, year of diagnosis _____________ |

| | | | | | |
|---|---|---|---|---|---|
| Bone Density Test | yes | no | If yes, year of test ___________ | normal | abnormal |
| Colonoscopy | yes | no | If yes, year of test ___________ | normal | abnormal |
| Heart Stress Test | yes | no | If yes, year of test ___________ | normal | abnormal |
| Heart Catheterization | yes | no | If yes, year of test ___________ | normal | abnormal |

Other ____________________________________________________________________

## For Male Patients Only

| | | | | | |
|---|---|---|---|---|---|
| PSA Test | yes | no | If yes, year of test ___________ | normal | abnormal |

## For Female Patients Only

| | | | | | |
|---|---|---|---|---|---|
| Mammogram | yes | no | If yes, year of test ___________ | normal | abnormal |
| Pap Smear | yes | no | If yes, year of test ___________ | normal | abnormal |
| Colposcopy | yes | no | If yes, year of test ___________ | normal | abnormal |

Number of pregnancies _____________ Number of Live Births ____________
Date of last menstrual cycle _______________________ Method of Birth Control __________________

## Please list any Medical Conditions:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

## Past Surgical History

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

## Social History

Marital Status (please circle one) Single Married Divorced Widowed

Occupation:________________________________________________________

Exercise Type? ________________ How Long? _______ Minutes? _________ How Often? ___________

| Substance Use | Current Use | Past Use | How often per week | How much per day |
|---|---|---|---|---|
| Smoking | | | | |
| Caffeine | | | | |
| Alcohol | | | | |
| Drug Use | | | | |

## Family History (please check appropriate box to identify all illnesses/conditions in your blood relatives)

| | Heart attack | High Blood Pressure | Stroke | Colon Cancer | Breast Cancer | Colon Polyps | Prostate Cancer | Other illness or Condition | Age if Living | Age of Death |
|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | |
| Mother | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | |
| Brother | | | | | | | | | | |
| Sister | | | | | | | | | | |

## Allergies (please list all allergies)

Allergen Reaction Date

1______________________________________________________________

2______________________________________________________________

3______________________________________________________________

4______________________________________________________________

## Current Medications

Medication Reason for taking Dosage Times per day

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

## Immunizations (please circle yes or no and write the date you were vaccinated)

Tetanus yes no Date ___________

Influenza yes no Date ___________

Pneumococcal yes no Date ___________

Hepatitis A Series yes no Date ___________

Hepatitis B Series yes no Date ___________

Gardasil Series (HPV) yes no Date ___________

Zoster Vaccine yes no Date ___________

Varicella yes no Date ___________

Have you ever had chicken pox? yes no Date ___________