Patient Paperwork

HCM | MEDICAL GROUP

Patient Name: _____

Date: _____

Current Weight:	
Current Height:	

MEDICATIONS - List all medications you take, prescription and non-prescription, and the dosage

□ I do not take any medications □ I have a list I will provide separately

Medication Name	Dosage	Frequency	For	Prescibed by

If more space is needed, please attach full list of medications on a separate sheet of paper.

MEDICAL HISTORY - Check if you are or have ever experienced the following conditions

	Condition		Condition		Condition
□	Alcoholism	□	Depression	□	Learning Disability/Delay
□	Anemia	□	Diabetes	□	Liver Disease
□	Anxiety	□	Diverticulitis/Diverticulosis	□	Neuropathy
□	Arthritis	□	Eye Disease	□	Obesity
□	Asthma	□	Fibromyalgia	□	Osteoporosis
□	Atrial Fibrillation	□	GERD	□	Pancreatitis
□	Autoimmune Disease	□	Gout	□	Peripheral Vascular Disease
□	Bleeding Disorder	□	Hearing Loss	□	Prostate/BPH
□	Cirrhosis	□	Heart Attack	□	Renal Disease
□	Colon Cancer	□	Hepatitis A / B / C	□	Rheumatoid Arthritis
□	Colon Polyps	□	High Cholesterol	□	Sleep Apnea
□	Congestive Heart Failure	□	Hitatal Hernia	□	Stroke/TIA
□	COPD/Emphysema	□	HIV/AIDS	□	Thyroid Disease
□	Coronary Artery Disease	□	Hypertension	□	Ulcerative Colitis
□	Crohn's Disease	□	Irritable Bowel Syndrome	□	Other

MEDICATION AND FOOD ALLERGIES - List all known allergies and intolerances (drugs, food, animals, latex, etc.)

□ No Known Allergies

Allergy	Reaction

Patient Name: _____

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SURGICAL HISTORY - List any serious injuries or surgical procedures, and approximate year.							
Procedure		Year	Procedure	Year	**Procedure**		Year
□	Appendectomy		□	Heart Surgery (Type):	□	Pacemaker	
□	Aneurysm				□	Prostate	
□	Bladder				□	Reflux Surgery	
□	Bowel Surgery		□	Hemorrhoid Surgery	□	Skin Surgery	
□	Brain		□	Hernia Surgery	□	Spinal Surgery	
□	Breast		□	Hysterectomy	□	Stent Placement	
□	CABG		□	Joint replacement:	□	Sterilization; Type	
□	Carotid				□	Testicles	
□	Carpal Tunnel				□	Thyroidectomy	
□	Colonoscopy		□	Kidney	□	Tonsillectomy	
□	Cosmetic Surgery		□	Liver Biopsy	□	Transplant Surgery	
□	C-Section		□	Liver Surgery	□	Upper Endoscopy (EGD)	
□	ERCP		□	Lung Surgery	□	Valve Replacement	
□	Eye Surgery		□	Orthopedic Surgery:	□	Varicose Veins	
□	Gallbladder Surgery				□	Other	
□	Gastric Surgery				□	Other	

HOSPITALIZATIONS - Non-surgical, please provide reason	
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____

FAMILY MEDICAL HISTORY							
□ Adopted	Mother	Father	Sibling:	Sibling:	Sibling:	Child	Child
Living	□	□	□	□	□	□	□
Deceased	□	□	□	□	□	□	□
Deceased Age:							
Barrett's Esophagus	□	□	□	□	□	□	□
Colon Polyps	□	□	□	□	□	□	□
Inflammatory Bowel Disease	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
High Cholestrol	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□
Liver Disease	□	□	□	□	□	□	□
Mental Disorder	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□
Cancer:	□	□	□	□	□	□	□
Breast	□	□	□	□	□	□	□
Esophagus	□	□	□	□	□	□	□
Lung	□	□	□	□	□	□	□
Uterine, Bladder, Ureter	□	□	□	□	□	□	□
Pancreas	□	□	□	□	□	□	□
Prostae	□	□	□	□	□	□	□
Stomach	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□

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Caffeine/Tabacco/Drug/Alcohol Use	Do you currently use tabocco products? □ Yes □ No			For how long? _____	
	□ Cigarettes ____ packs per day	□ Cigar/Pipe ____ amount per day		□ Chewing ____ amount per day	
	Have you ever tried to quit? □ Yes □ No				
	Have you previously used tobacco products? □ Yes □ No			For how long?	
	□ Cigarettes	□ Cigar/Pipe	□ Chewing	When did you quit?	
	Alcohol Use:	□ Yes □ No			
	Beer:	□ Occasional	□ Weekly	□ Daily	□ Never
	Wine:	□ Occasional	□ Weekly	□ Daily	□ Never
	Liquor:	□ Occasional	□ Weekly	□ Daily	□ Never
	Do you consume drinks containing Caffeine? □ Yes □ No				
	If yes, how many drinks do you consume per day _____				
	Drug use:	□ Yes □ No	Type _____	Last Usage _____	
	Have you ever been treated for addiction?		□ Yes □ No		

Personal	Education	
	How many children do you have?	How many children at home?
	Type of Exercise? _____	□ Daily □ Weekly □ Monthly □ Yearly
	Lives With	
	Occupation	□ Full Time □ Part time
	Religious Preference	

Vaccines	Last Flu Vaccination	Date
	Last Pneumonia (Circle: Prevar 13 and/or Pneumovax 23) Vaccination(s)	Date
	Last Shingles (Zostavax) Vaccine	Date
	Last Tetnus (Circle: Tdap or Td) Vaccine	Date
	HepatitisB Vaccine, Did you complete the series? □ Yes □ No	Dates:

Screenings	Last Breast Cancer Screening (Mammogram)	Date
	Last Abdominal Aortic Aneurysm (AAA) Screening	Date
	Last Lung Cancer Screening	Date
	Last Bone Density Screening (DEXA)	Date
	Last Prostate Cancer Screening (PSA)	Date

Testing	Diagnostic Testing - List any imaging you have had pertaining to the curent issues					
		Ultrasound	CT Scan	MRI	Labs	Other
	Date					
	Where					

Specialists	Please list all doctors you currently see			
	Name	Specialty	Address	Phone