Providence Family Medicine Center

Legal name: Last First Middle _____ **Preferred name:** _____ **Pronoun:** (i.e. she, he, they, name, etc.) _____			**Ethnicity:**
Date of Birth: Month Day Year		**Email address:**	
Home phone ( ) - Ok to leave voicemail? Yes No	**Cell phone** ( ) - Ok to leave voicemail? Yes No	**Work phone** ( ) - Ok to leave voicemail? Yes No	**Best number to use:** ☐ Home ☐ Cell ☐ Work
Emergency contact: Name Phone Relationship to you			
If you are under 18: **Parent/Guardian:** Name Phone Relationship to you			

PERSONAL HEALTH HISTORY: *Circle if you have been diagnosed with any of these conditions.*

Anemia	Depression	Meningitis
Anesthesia	Complications	Diabetes Myocardial Infraction
Anxiety	Emphysema	Nerve/Muscle Disease
Arthritis	Environmental	Allergies Osteoporosis
Asthma	Gerd	Seizures
Blood Transfusion	Glaucoma	Sickle Cell Anemia
Cancer	Heart Murmur	Stroke
Cataracts	HIV/AIDS	Substance Abuse
Congestive Heart Failure	Hyperlipidemia	Thyroid Disease
Clotting Disorder	Hypertension	Tuberculosis
COPD	Kidney Disease	

Other: _____

HEALTH SCREENINGS: (please indicate date of last check):

Colon screening: _____ Mammogram: _____ Pap Smear: _____
Bone Density: _____TB Test: _____ Fasting Labs: _____ HIV test: _____
Hepatitis C: _____ PSA: _____

SURGICAL HISTORY: *Please list any surgeries, hospitalizations, and the date and location.*

Surgery or Reason for Hospitalization	Approximate Date	Location

CURRENT MEDICATIONS: *Please include herbals, supplements, and over the counter medications.*

Preferred Pharmacy Name: _____**Location**: _____

☐ I do not take any medicines.

Medication	Dose	Frequency	Reason for Taking	When Started

ALLERGIES: *Please list all Medication allergies, and the reaction, if known*

☐ No known allergies

Allergy	Reaction		Allergy	Reaction

ADVANCE DIRECTIVE/CODE STATUS: (i.e. Living Will, Do Not Resuscitate, Power of Attorney, etc)

☐ None ☐ Yes, but not on file with this clinic ☐ Yes, on file with this clinic

SEXUAL ORIENTATION AND GENDER IDENTITY:

What is your sexual orientation?

☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know

☐ Choose not to disclose

Sexual Orientation Additional Comments: _____

What is your gender identity?

☐ Female ☐ Male ☐ Transgender Female / Male to Female ☐ Transgender Male / Female to Male

☐ Other ☐ Choose not to disclose

Gender Identity Additional Comments: _____

What was your sex assigned at birth?

☐ Female ☐ Male ☐ Unknown /Uncertain ☐ Not Recorded on birth certificate ☐ Choose not to disclose

FAMILY HEALTH HISTORY: *Please list any known health problems in the following family members:*

	Alive	Age(s)	Deceased	Medical Problems
Mother				
Father				
Sister(s)				
Brother(s)				

OBSTETRICS AND GYNECOLOGY HISTORY:

Age Menstruation (period) started: _____

Last Pap smear date: _____

Have you had an Abnormal PAP Smear? Yes/No When?_____

Are you currently pregnant? Yes/No Last Menstrual Period: _____

Have you ever been pregnant? Yes/No

Total number of times pregnant: _____ Total number of live births: _____

Miscarriages: _____ # Abortions _____ # Ectopic Pregnancies: _____

SOCIAL HISTORY:

Occupation: _____

Where were you born and raised? _____

Marital Status: (circle one) Single Married Divorced Cohabitating

Children? (Names, ages): _____

Others living with you? _____

Sexually active? *Please circle* Y/N If yes, are you sexually active with men, women or both? _____

MOOD	0 = Not at all	1 = Several days	2 = More than half the days	3 = Nearly every day
During the past two weeks, have you been bothered by little interest or pleasure?	○	○	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○	○	○

HABITS:

Regular Exercise? Yes ___ No ___ How often? _____ times per week. Type: _____

Do you smoke? _____ If yes, age you started smoking? _____ Year you quit? _____Packs per day? ____

Smokeless (Chewing) Tobacco Use? _____

Are you currently in recovery for alcohol or substance abuse? YES ☐ NO ☐

Alcohol: One drink = 

12 oz. Beer  5 oz. Wine  1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?	O	O
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	O	O

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin)

	None	1 or More
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	O	O