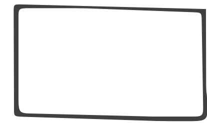

Premier Health Center

History Intake Form

Name:______________________________ Date:______________

Address:______________________________ City:____________State:_________ZipCode:______

Date of Birth:______________ Phone#:____________________ Insurance:____________________

Pharmacy: Pharmacy Phone#:____________________

Previous Primary Care MD: Cardiologist:____________________

OB/Gyn: Pain/Neuro:____________________

Other Specialist:______________________________ Advance Directive: YES / NO (Circle One)

List past surgeries and approximate dates, including cosmetic procedures: ____________________

____

Have you been admitted to the hospital in the last 10 years? Yes______ No_____ If yes, please explain___________

List all medications that you are currently taking, including strength and number of times a day:

________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________

List all allergies:____

Smoking (type, amount, years)____________________ Alcohol (type & amount per day/week)____________________

If former smoker, date quit: ____________ Other drug use (type & amount per week)____________________

Family History: Has any blood relative had the following? Check all that apply.

	Mother	Father	Sibling	Other
Heart Disease				
High Blood Pressure				
High Cholesterol				
Diabetes				
Breast Cancer				
Colon Cancer				
Other				

	Mother	Father	Sibling	Other
Stroke				
Melanoma				
Prostate Cancer				
Migraines				
Depression				
Suicide				
Other				

Past Medical History: Have you had any of the following? Check all that apply.

Heart Attack____	Cancer____	Stroke____	High Blood Pressure____	Anemia____
Arthritis____	Hepatitis____	HIV/AIDS____	High Cholesterol____	TB____
Diabetes____	Seizures____	Asthma____.	Stomach Ulcer____	Blood Clots____
Irregular HR____	Depression	Kidney Stone____	Psychiatric Disorder____	Kidney Disease____

Other____

Date of Last:

Mammogram_______	Colonoscopy_______	Pap Smear_______	Eye Exam_______
PSA Test_______	Chest X-ray_______	Arteriogram_______	Cardiac Stress Test
Flu Shot_______	Pneumonia Shot_______	Shingles Vaccine_	Tetanus Shot_______

I acknowledge that all this information is correct and accurate. By signing this document, I understand that I am held accountable for any false information which could impede proper treatment provided by the physicians and staff of Premier Health Center. I am aware that I am responsible for providing up-to-date information to physicians and staff currently and as changes occur.

Signature: X______________________________ Date:____________________

*Please note: If initial visit scheduled after review of History Intake Form information, final acceptance of primary care patients will be evaluated and decided by attending physician at that visit.

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