Thank you for taking the time to complete this form. This will assist us with the new Electronic Health Record.

Name: **Date of Birth:**
(Please print clearly)

SJ Family Medical Center - Physician Name:

Current Medications*: (include vitamins, supplements, over the counter medications, prescribed meds and others)
***Please attach an additional page to this form if your medications do not fit in the following lines.**

Medication Name	Strength (i.e. 30mg)	Instructions (i.e. take one tablet daily)

Preferred Pharmacy (indicate pharmacy name and address):______________________________

Do you have allergies? No or Yes (if yes, please complete the allergy section below and include your allergies to medication, food and environmental)

What are you allergic to? (list below)	What is the reaction? (i.e. swelling, hives, etc)	Is it a critical reaction?
		Yes No
		Yes No
		Yes No

Medical Problems: Check the appropriate box (es) to indicate an active problem or a past problem. Include the date for past problems, if known. Please use the 'Other' boxes to record your Medical Problem(s) if it is not on the list below.

Active	Past		Active	Past	
☐	☐	No major medical problems	☐	☐	Infertility ______
☐	☐	Asthma ______	☐	☐	Kidney Disease ______
☐	☐	A Fib ______	☐	☐	Kidney Stone ______
☐	☐	Anemia ______	☐	☐	Liver Disease ______
☐	☐	Anxiety ______	☐	☐	MI (heart attack)______
☐	☐	Autoimmune Disorder ______	☐	☐	Neurologic Disorder ______
☐	☐	Biliary Cirrhosis ______	☐	☐	Osteoarthritis ______
☐	☐	Blood Transfusions ______	☐	☐	Osteoporosis ______
☐	☐	Brain Tumor ______	☐	☐	Peripheral Vascular Disease (PVD)__
☐	☐	Cerebrovascular Disease ______	☐	☐	Peptic Ulcer (P U D) ______
☐	☐	Cirrhosis ______	☐	☐	Rheumatoid Arthritis ______
☐	☐	C V A / Stroke ______	☐	☐	Seizure Disorder ______
☐	☐	C O P D ______	☐	☐	Thyroid Disorder ______
☐	☐	Colon Cancer ______	☐	☐	Tuberculosis (TB)______
☐	☐	Coronary Heart Disease ______	☐	☐	Heart Valve Disease ______
☐	☐	Crohn's Disease ______	☐	☐	U T I-Recurrent ______
☐	☐	Chronic Renal Failure (CRF) ______	☐	☐	Varicose Veins/Phlebitis ______
☐	☐	Depression ______	☐	☐	Abnormal Pap Smear ______
☐	☐	Diabetes, Type 1 **onset date:** ______	☐	☐	Breast Disease ______
☐	☐	Diabetes, Type 2 **onset date:** ______	☐	☐	Breast Cancer ______
☐	☐	Diverticulitis ______	☐	☐	Cervical Cancer ______
☐	☐	DVT ______	☐	☐	D E S Exposure ______
☐	☐	G I Bleed ______	☐	☐	Diabetes in Pregnancy ______
☐	☐	G E R D (Reflux) ______	☐	☐	RH Sensitized ______
☐	☐	Hemochromatosis ______	☐	☐	Uterine Anomaly ______
☐	☐	High Cholesterol ______	☐	☐	Other ______
☐	☐	High Blood Pressure ______	☐	☐	Other ______
☐	☐	Hypothyroid (under active) ______	☐	☐	Other ______
☐	☐	Hyperthyroid (over active) ______	☐	☐	Other ______
☐	☐	Hepatitis A ______	☐	☐	Other ______
☐	☐	Hepatitis B ______	☐	☐	Other ______
☐	☐	Hepatitis C ______			

Name: **Date of Birth:**
(Please print clearly)

Surgical History: Check the appropriate box (es) to indicate your surgical history. Include the date of the surgery, if known and specify (R) right, (L) left, or (B) bilateral when applicable. Please use the 'Other' boxes to record your Surgical History if it is not on the list below.

- ☐ No major medical problems
- ☐ Abdominal Surgery (specify) ______________
- ☐ Termination of Pregnancy _______________
- ☐ Adenoidectomy ________________________
- ☐ Amputation (specify) ___________________
- ☐ Anesthesia Problem: No
- ☐ Anesthesia Problem: Yes, specify reaction __
- ☐ Aortic Valve Replacement _______________
- ☐ Appendectomy ________________________
- ☐ Arterial Blockage repair _________________
- ☐ AV Fistula Creation ____________________
- ☐ (AAA) Repair _________________________
- ☐ A-F Bypass R L B ______________________
- ☐ Back Surgery (specify) __________________
- ☐ Breast Implants (enlarge) R L B __________
- ☐ Breast (Lumpectomy) R L B _____________
- ☐ Breast Reduction R L B ________________
- ☐ Breast Surgery (specify) R L B __________
- ☐ Bronchoscopy _________________________
- ☐ Bunion Metatarsal, part removal of ________
- ☐ CABG ______________________________
- ☐ Cardiac Surgery (specify) ______________
- ☐ Carotid Endarterectomy R L B ___________
- ☐ Carpal Tunnel R L B ___________________
- ☐ Cataract Extraction ____________________
- ☐ Cervical Spine Disk Surgery ______________
- ☐ Cesarean Section _____________________
- ☐ Colectomy ____________________________
- ☐ Cholecystectomy (Gall Bladder removal)____
- ☐ Colon Resection _______________________
- ☐ Coronary Artery Stent __________________
- ☐ Craniotomy ___________________________
- ☐ Cystoscopy ___________________________
- ☐ Dilation & Curettage (D&C) ______________
- ☐ Dental Procedure ______________________
- ☐ Fundoplasty (laparoscopy) _______________
- ☐ Gastric Bypass _______________________
- ☐ Glaucoma Surgery R L B ________________
- ☐ Hemorrhoidectomy ____________________
- ☐ Hip Replacement-total R L B ____________
- ☐ Ileostomy / Jejunostomy ________________
- ☐ Interventional pain procedure _____________
- ☐ Knee Arthroscopy R L B ________________
- ☐ Knee Replacement R L B _______________
- ☐ Kyphoplasty __________________________
- ☐ Laparoscopic-Gastric Band ______________
- ☐ Laparoscopy, Diagnostic ________________
- ☐ Lumpectomy w/nodes (breast) R L B _______
- ☐ Mastectomy R L B ______________________
- ☐ Mitral Valve Replace ____________________
- ☐ Nephrectomy R L B _____________________
- ☐ Oopherectomy R L B ____________________
- ☐ Pacemaker ____________________________
- ☐ Parathyroidectomy _____________________
- ☐ Pneumonectomy R L B __________________
- ☐ Post-op delirium _______________________
- ☐ Prostatectomy ________________________
- ☐ PTCA _______________________________
- ☐ Remove Kidney Stone R L _______________
- ☐ Remove Kidney-partial R L _______________
- ☐ Repair Inguinal Hernia R L _______________
- ☐ Repair Umbilical Hernia _________________
- ☐ Rhinoplasty __________________________
- ☐ Rotator Cuff Repair R L B _______________
- ☐ Shoulder Manipulation w/anesth R L B ______
- ☐ Shoulder Surgery R L B _________________
- ☐ Sinus Surgery ________________________
- ☐ Spinal Fusion _________________________
- ☐ Spinal Fusion-Neck ____________________
- ☐ Splenectomy _________________________
- ☐ Surgical Complication: No
- ☐ Surgical Complication: Yes, specify ________
- ☐ Total Abd. Hysterectomy w/BSO __________
- ☐ Total Abd. Hysterectomy ________________
- ☐ Total Vaginal Hysterectomy ______________
- ☐ TURP (prostate)_______________________
- ☐ Thyroidectomy ________________________
- ☐ Thyroidectomy- Partial __________________
- ☐ Tonsillectomy ________________________
- ☐ Transplant of Kidney R L ________________
- ☐ Tunneled Dialysis Catheter ______________
- ☐ Tympanostomy Tube __________________
- ☐ UPPP _______________________________
- ☐ Urinary incontinence surgery _____________
- ☐ Vertebroplasty ________________________
- ☐ Other ________________________________
- ☐ Other ________________________________
- ☐ Other ________________________________
- ☐ Other ________________________________
- ☐ Other ________________________________
- ☐ Other ________________________________

Please be sure your name and date of birth are written on this form.

Name: **Date of Birth:**
(Please print clearly)

Family Medical History: Check the appropriate box (es) to indicate your family history and list which family member was diagnosed (father, mother, brother, sister, etc). List the age when diagnosed if known. Please use the 'Other' boxes to record your Family Medical History if it is not on the list below.

- ☐ Unknown Family Medical History
- ☐ Adopted Unknown Family Medical History
- ☐ Alcoholism ______
- ☐ Alzheimer's ______
- ☐ Anemia ______
- ☐ Anesthetic Complication ______
- ☐ Angina ______
- ☐ Anxiety ______
- ☐ Arthritis ______
- ☐ Asthma ______
- ☐ Bipolar Disorder ______
- ☐ Birth Defects______
- ☐ Bleeding Disease ______
- ☐ Breast Cancer ______
- ☐ Cervical Cancer ______
- ☐ Coronary Heart Disease (CHD) <65 female ______
- ☐ Coronary Heart Disease (CHD) <55 male ______
- ☐ Colon Cancer ______
- ☐ Depression ______
- ☐ Diabetes ______
- ☐ Endometriosis ______
- ☐ Growth Development ______
- ☐ High Cholesterol ______
- ☐ Headaches ______
- ☐ Heart Disease______
- ☐ High Blood Pressure______
- ☐ Kidney Disease ______
- ☐ Lung Cancer ______
- ☐ Lung/Respiratory Disease ______
- ☐ Melanoma ______
- ☐ Migraines ______
- ☐ Osteoporosis ______
- ☐ Ovarian Cancer ______
- ☐ PMS ______
- ☐ Parkinson's ______
- ☐ Polycystic Kidney ______
- ☐ Prostate Cancer ______
- ☐ Psychiatric Care ______
- ☐ Seizures ______
- ☐ Severe Allergies ______
- ☐ Suicide ______
- ☐ Stroke ______
- ☐ Thyroid Problems ______
- ☐ Uterine Cancer ______
- ☐ Weight Disorder ______
- ☐ Other ______
- ☐ Other ______
- ☐ Other ______
- ☐ Other ______
- ☐ Other ______

Social History: circle or print answers below.

Marital Status: Divorced Life Partner Married Separated Single Widowed
Number of Children: none 1 2 3 4 5 6 7 other ____
Occupation: ______
Smoker: Never Former Current
Alcohol use: Yes No
Regular Exercise: Yes No
Helmet use: Yes No
Smoke Detector: Yes No
Seat Belt use: Yes No

Health Maintenance: Please indicate the date(s) performed, approximate if necessary, if you have received the following tests:

Colonoscopy:
Bone Density/Dexa Scan:
Mammograms:

* If your medication list does not fit on this form, upon your request some pharmacies may provide you with a print out of your medications. If you wish, the pharmacy print out may be attached to this form, or you may attach your own written list to this form.

Please be sure your name and date of birth are written on this form.

For Internal Use Only, Entered By: ______