Platte Valley Medical Group

Date _____

Name_____ DOB_____

Primary Care Physician_____ **Referring Physician**_____

List all medication you take prescription and nonprescription

Primary Pharmacy_____ No Medications_____

Medications	Medication Dose
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Medication Allergies

Medication	Reaction
• _____	_____
• _____	_____
• _____	_____
• _____	_____

Past Medical History

(Closest date of diagnosis if known)

- o Alcohol Dependence __/__/___
- o Chronic Sinusitis __/__/___
- o Allergies (other)_____
- o Chronic Back pain __/__/___
- o Anxiety __/__/___
- o Diabetes Type 1 __/__/___
- o Anemia __/__/___
- Diabetes Type 2 __/__/___
- o Arthritis __/__/___
- o Depression __/__/___
- o Headaches/Migraines __/__/___
- o Insomnia __/__/___
- o Osteoarthritis __/__/___
- o Osteoporosis __/__/___
- o Tinnitus __/__/___
- o Rheumatoid Arthritis __/__/___
- o Seizures/ epilepsy __/__/___
- o Hyperthyroid __/__/___
- o Hypothyroid __/__/___
- o Other_____
- o Cancer
  Type:_____ __/__/___
  Type:_____ __/__/___
- o Angina __/__/___
- o Atrial Fibrillation __/__/___
- o Atrial Flutter __/__/___

- o Circular Disease_____
- o Congestive Heart Failure __/__/__
- o Heart Attack (MI) __/__/__
- o Heart Failure __/__/__
- o High Cholesterol __/__/__
- o Hypertension __/__/__
- o Hypotension __/__/__
- o Palpitations __/__/__
- o Stroke (CVA) __/__/__
- o Varicose Veins __/__/__
- o Other_____ __/__/__

- o Asthma __/__/__
- o COPD __/__/__

- o Emphysema __/__/___
- o Sleep Apnea __/__/___
- o Other_____ __/__/___

- o Colitis __/__/___
- o Crohn's disease __/__/___
- o Irritable Bowel Syndrome__/__/___
- o Duodenal/ peptic ulcers __/__/___
- o GERD (esophageal reflux)__/__/___
- o Hepatitis A__ B__C_ __/__/___
  Other_____ __/__/___

Surgical History

- o Angiography (heart cath)
- o Angiography w/ Stent
- o Appendectomy
- o Arthroscopy Knee R)_ L)_
- o Back surgery
  Type_____
- o Biopsy Breast__ Liver_ Prostate__
  Other_____
- o Bowel Resection
- o Coronary Artery Bypass Graft (CABG)_
  #vessels_____
- o Other_____

- o Carpal Tunnel Release R)__L)__
- o Cataract Extraction R)__L)__ __/__/___
- o Cholecystectomy __/__/___
- o Colonoscopy __/__/___
- o Gastric Bypass __/__/___
- o Hernia Repair __/__/___
- o Hip Replacement R)__L)__ __/__/___
- o Knee Replacement R)__L)_ __/__/___
- o LASIK
- o Open Reduction Internal Fixation (ORIF)
  Which limb_____ __/__/___
- o Pacemaker __/__/___
- o Thyroidectomy __/__/___
- o Tonsillectomy __/__/___

Female Medical - Surgical History

- o Augmentation Mammoplasty__/__/__
  Abnormal PAP __/__/__
- o Bilateral Tubal Ligation __/__/__
  Uterine Fibroids __/__/__
- o Abnormal PAP __/__/__
  Breast biopsy R_ L_ __/__/__
  Abnormal Mammogram __/__/__
  Mastectomy B)_R)_ L) __/__/__
- o Cesarean Section __/__/__
  Childbirth __/__/__

- o D & C (Dilation and Curettage)__/__/__
  Colposcopy __/__/__
- o Endometriosis __/__/__
  Hysterectomy __/__/__
  T_ V_ P_ A_
- o Other_____ __/__/__
  Breast Reduction __/__/__

Male Medical, Surgical History

- o Elevated PSA __/__/__
- o Benign Prostatic Hyperplasia (BPH) __/__/__
- o Impotence __/__/__
- o Biopsy Prostate __/__/__
- o Transurethral Resection of Prostate (TURP) __/__/__
- o Vasectomy __/__/__

Family History

Please check any of the following conditions onset and/ or cause of death

- o Adopted

	Mother	Father	Siblings (B/S)	Grandparent (P/M)	Child (S/D)	Cause of Death
Alcoholism	_____	_____	_____	_____	_____	Y N
Asthma	_____	_____	_____	_____	_____	Y N
COPD	_____	_____	_____	_____	_____	Y N
Congestive	_____	_____	_____	_____	_____	Y N
Heart Failure	_____	_____	_____	_____	_____	Y N
Heart Attack (MI)	____	_____	_____	_____	_____	Y N
Stroke (CVA)	_____	_____	_____	_____	_____	Y N
Peripheral	_____	_____	_____	_____	_____	Y N
Other	_____	_____	_____	_____	_____	Y N
Cancer:	_____	_____	_____	_____	_____	Y N
Type_____						
Type_____						
Diabetes	_____	_____	_____	_____	_____	Y N
High Cholesterol	_____	_____	_____	_____	_____	Y N
Hypertension	_____	_____	_____	_____	_____	Y N
Migraines	_____	_____	_____	_____	_____	Y N
Seizures, epilepsy	_____	_____	_____	_____	_____	Y N

Social History

Have you ever used tobacco? Yes___ No__ Currently Use__ Formerly Used___ Years Used__ Year Quit _____

Packs per day_____ Type: Cigarette___ Can__ Cigars__ Vapor__ Other__

Do you drink caffeine? Yes___ No___ Type _____ _____ Amount Daily _____

Do you drink alcohol? Yes___ No ___ Type_____ _____ Amount Daily_____

Currently__ Daily__ Weekly__ Occasionally__ Rarely___ Last Drink _____

Immunizations- Please check and indicate immunization date to all that apply

Pneumococcal (PPV23) __/__/__ Influenza (LAIV) __/__/__ Adult Tetanus, Diphtheria, Pertussis (Tdap) __/__/__

Prevnar 13 __/__/___ Zoster __/__/__ Other: _____ Other:_____ Other:_____

New patients please have consent form signed for release of Medical History from previous Medical Clinics.

Please bring the forms with you to your appointment. Thank you.