Patient Name:____ Patient Date of Birth:_________________

Patient History Form

Preferred Pharmacy: ____

PCP (Primary Care Physician): ____

Allergies:

____

____

Please list any medications that you are now taking. Please include over the counter medications and vitamins or supplements: Place a check mark in the box if prescribed by Careteam+

Name of Medication, Vitamin or Supplement, Strength. and number of times per day	
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

Please check any conditions that you have now, or have had in the past.

☐ Abnormal Pap Smear ☐ ADHD/ADD ☐ Anemia

☐ Anxiety/Depression ☐ Arthritis ☐ Asthma/COPD

☐ Cancer- Type:________________________ ☐ Cataracts ☐ Colitis

☐ Diabetes ☐ Headaches ☐ Heart Disease

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ High Blood Pressure ☐ High Cholesterol

☐ HIV/AIDS ☐ Kidney Disease ☐ Seizures

☐ Stroke ☐ Thyroid Disorders ☐ Tuberculosis

☐ Sexually Transmitted infection (please list):____

Please list other medical condition(s):

____

____

____

Please list any past surgeries (include date):

____

____

Patient Name:____ Patient Date of Birth:_________________

____

Date of Last Colonoscopy:__________________ **Date of last Pap Smear:**________________________ **Date of last mammogram:**_________________

Family Member	If Living		If Deceased	
	Age	Health Conditions	Age at Death	Cause
Father				
Mother				
Siblings				

Do you smoke? ☐ yes ☐ no **Have you ever smoked?** ☐ yes ☐ no

Do you use tobacco or tobacco products? ☐ yes-what type:____ ☐ no

Do you drink alcohol? ☐ yes ☐ no ☐ not any more

How often do you drink alcohol?: ☐ never ☐ rarely ☐ socially ☐ occasionally

Do you now, or have you ever used illicit or street drugs? ☐ yes: please list________________________________ ☐ no

Do you use any caffeine? ☐ yes-what type:____ ☐ no

Sexual Orientation

☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual

☐ Bisexual ☐ Other

☐ Don't Know ☐ choose not to disclose

What is your current gender identity?

☐ Male ☐ Female

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

☐ Genderqueer, neither exclusively male nor female ☐ choose not to disclose

What sex were you assigned at birth on your original birth certificate?

☐ Male ☐ Female

Patient Name:____ Patient Date of Birth:_________________

Are you sexually active?

☐ yes ☐ no ☐ previously

Safer sex/birth control method? ____

____ _______________________

(Signature of patient/guardian/authorized representative) **(Date)**