Premier Family Medicine, LLC

Patient Health Information

(for doctor's use)

Personal Information

Full Name: ____ Date of Birth: _________________

Main Contact Phone Number: _____________________________ Social Security Number: _________________

Family Information

Marital Status: _____________ Spouse's Full Name: ____

Children's Names & Ages: ____ ____ _______ yrs. M / F

(√ check those who) (will be patients here) ____ ____ _______ yrs. M / F

____ ____ _______ yrs. M / F

____ ____ _______ yrs. M / F

Professional Information

Occupation: ______________________ Employer:___________________________ Work Phone: ______________

Personal Medical History √ **_Previous Doctor:_**____

Condition	√
Anemia	
Asthma	
Cancer	
Chronic Pain	
Depression / Anxiety	
Diabetes	
Heart Disease	
High Blood Pressure	
Lung Disease	
Migraine Headache	
Seasonal Allergies	
Seizures	
Stomach/Intestinal Problem	
Stroke	
Thyroid Problem	

Medication Allergies: *(list all medication allergies)*

Hospitalization / Surgeries	Year

List Medications you are currently taking	Dosage	Times Per Day

Family History	Deceased	Health Problems
Father		
Mother		
Siblings		
Children		

Habits

How many pack of cigarettes do you smoke a day: _________

How frequently do you drink alcohol? (circle one) none rarely monthly weekly daily

Current Medical Problems	*Yes*	*No*	*Comments*
Severe or unusual headache			
Hearing Problems			
Problems with vision (other than nearsightedness or farsightedness			
Sinus Problems or hay fever			
Hoarseness			
Problems with teeth or gums			
Severe skin problems			
Weight loss or gain			
Chest pains or discomfort			
Shortness of breath			
Cough or phlegm			
Stomach problems (pain, nausea, or vomiting)			
Diarrhea or constipation			
Blood in bowel movements or black bowel movements			
Difficulty or pain in urinating or blood in urine			
Painful joints			
Sexual difficulties			
Depression			
Severe sleep problems			
Severe stress			
Other, describe:			