

Fairvue Family Wellness at Sumner Station

Patient Health Information Form

Date: _____	
Patient Name: _____	DOB: _____
Pharmacy (<i>name and number</i>) _____	
(All new prescriptions and refills will be submitted electronically to your designated pharmacy)	

What is the reason for your visit today? _____	
Were you born between 1946 and 1964? _____	Have you been tested for Hepatitis C? _____

Medical History: (Please circle all that apply)

- | | | | |
|--------------------|-----------------|--------------------------|--------------|
| Heart Disease | Stroke | High blood pressure | Diabetes |
| High Cholesterol | Asthma | COPD | Seizure |
| Thyroid problems | Liver disease | Hepatitis C | Hepatitis B |
| Acid Reflux | Irritable Bowel | Back pain | Fibromyalgia |
| Migraines | Anxiety | Depression | Crohn's |
| Ulcerative Colitis | Kidney disease | Cancer (list type) _____ | |

In general do you have any of the following symptoms? (Circle all that apply)

- | | | |
|---------------------|---------------------|------------------------|
| Trouble swallowing | Hoarseness | Constipation |
| Always Tired | Rectal Bleeding | Rectal Pain |
| Loss of appetite | Sore throat | Diarrhea |
| Weight loss/gain | Cough | Black/tarry stools |
| Shortness of breath | Hemorrhoids | Heartburn/acid reflux |
| Hepatitis | Loose stools | Abdominal pain |
| Nausea | Colon cancer | Abdominal bloating |
| Ulcers | Chest pain | Pelvic pain |
| Falls/stumbling | Vomiting/dry heaves | Recent imaging/labwork |

Past Surgical History:

Surgery _____	Date: _____
Surgery _____	Date: _____
Surgery _____	Date: _____

Recent Hospitalizations/REASON: _____

Family History: (Check all that apply) parents alive or deceased

	Colon cancer	Other cancer	Hypertension	Heart Disease	Liver Disease	Abnormal Cholesterol	diabetes	Thyroid Problems
Mother								
Father								
Brother								
Sister								
Son								
Daughter								
Grandparents								

Medications: (List all prescription and over the counter medications that you are currently taking)

Medication	Reason for taking	Dosage	Directions
Do you take aspirin? Yes/NO			

Allergies: (circle all that apply)

- Sulfa Penicillin Statins (cholesterol medication) Codeine
- Latex Other allergies: _____

Social History: (Check all that apply)

Tobacco Use: None ___ 1pk/day ___ 1+pk/day ___ former smoker (year stopped) ___
 Alcohol Use: None ___ social ___ 1/day ___ 2-3/day ___ 4+/day ___ year stopped ___
 Street Drugs: Never ___ In the past ___ Occasionally ___ Frequently ___

Signature: _____ **Date:** _____