



**PRIMARY CARE FAMILY & SOCIAL HISTORY**

Please check all other Premier locations where you are also a patient.	<input type="checkbox"/> St. B	<input type="checkbox"/> Richview	<input type="checkbox"/> OBGYN
	<input type="checkbox"/> Governor's Sq	<input type="checkbox"/> Eye Center	
	<input type="checkbox"/> ENT	<input type="checkbox"/> Imaging	

**Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_

**Employed:**  Yes  No

**Please Complete This Section**

Employer	Occupation	Physical Restrictions	Employment Status	Retire Date

**Occupational Hazards (list):** \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Widow **Do You have Children:**  Yes  No

Please list others who you consider to be your support network (friends, family members, co-workers, etc.):

\_\_\_\_\_

**Tobacco Use:**  Yes  No  Previous Smoker. If Yes, have you tried to quit:  Yes  No. Other smokers in home:  Yes  No

**Alcohol Use:**  Yes  No  Previous Use. If Yes, how much: \_\_\_\_\_ and how often: \_\_\_\_\_

**Advance Directives:**  None  Do Not Resuscitate (DNR)  Living Will  Durable Power of Attorney (POA)

**Your Past Medical History:**

**Have you been diagnosed with any of the following?**

- |                             |  |  |  |
|-----------------------------|--|--|--|
| Allergies                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis C                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irritable Bowel Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Atrial Fibrillation         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Benign Prostate Hypertrophy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Myocardial Infarction (Heart Attack)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clots                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoarthritis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema (COPD)            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Peptic Ulcer Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crohn's Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Disease (Kidney Disease)         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke (CVA)                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gallbladder Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                             |  | OTHER:                                 | _____  |

**Your Past Surgery History:**

**Have you had any of the following surgical procedures?**

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Year</b> _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Year</b> _____
Angioplasty (heart balloon procedure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Angioplasty w/Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Small Bowel Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Thyroidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthroscopy on Knee (Scope)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Tonsillectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Back Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<b>GENDER SPECIFIC (Female):</b>		
Coronary Artery Bypass Graft (CABG)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Augmentation (Breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Carpal Tunnel Release	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Bilateral Tubal Ligation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataract Removal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Breast Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cholecystectomy (Gall Bladder removed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Cesarean Section	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Colon Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	D and C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Colostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gastric Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Mastectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hernia Repair	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Benign Uterine Tumor Removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hip Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Reduction (Breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Knee Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Abdominal Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
LASIK	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Ovaries Removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Liver Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Vaginal Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
			Ovaries Removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Open Reduction Internal Fixation (ORIF)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

OTHER: \_\_\_\_\_

**Family History: Please let us know about your family's (Blood Relatives Only: Parents, Brothers, Sisters, Children) health. Please answer these questions as completely as you can.**

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Age of Onset or Death</b> _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Age of Onset or Death</b> _____
ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Irritable Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Learning Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Coronary Artery Disease (heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cerebrovascular Accident (stroke)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Osteoporosis (brittle bones)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Polyps in colon	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Developmental Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Renal Disease (Kidney Disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

OTHER: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_