☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag at Home

HEALTH HISTORY

Name: _____ Date: _____

Date of Birth: _____

Reason for Today's Visit: _____

Previous Primary Care Physician: _____ Phone Number: _____

Current Specialists:

1) Name: _____ Specialty: _____ Phone Number: _____

2) Name: _____ Specialty: _____ Phone Number: _____

Note: If you are currently seeing more specialists than the space above allows, please list the additional specialists on the back of this form.

Allergies: Any known drug allergies? ☐ Yes ☐ No

Please list all allergies including food, medications and environmental and reaction.

_____

_____

Do you currently take any medications on a regular basis? ☐ Yes ☐ No

If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

Medication	Dosage	Frequency

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Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

MEDICAL HISTORY

Illness and Conditions - Do you have or have you ever had any of the following:

	Year:
☐ Alcoholism	_____
☐ Anxiety	_____
☐ Anemia	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Bleeding Problems	_____
☐ Birth Defects	_____
☐ Cancer, Type: _____	_____
☐ Colitis	_____
☐ Concussion	_____
☐ Depression/Nervous Breakdown	_____
☐ Diabetes	_____
☐ Emphysema	_____

Have you had any past medical problems?

☐ Yes ☐ No If yes, list below:

_____

_____

_____

_____

_____

Have you had any previous surgeries or hospitalizations?

☐ Yes ☐ No If yes, list details and date below:

_____

_____

_____

_____

_____

_____

PATIENT LABEL

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	Year:
☐ GERD/Heartburn/Reflux	
☐ Gout	
☐ Heart Attack/Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Kidney Disease	
☐ Lupus	
☐ Liver Disease/Hepatitis	
☐ Migraine Headache	
☐ Mitral Valve Prolapse/Murmur	
☐ Osteoporosis	
☐ Prostate Enlargement (BPH)	
☐ Rheumatoid Arthritis	
☐ Seizure Disorder	
☐ Sexually Transmitted Disease	
☐ Skin Problems	
☐ Stroke	
☐ Thyroid Disease	
☐ Tuberculosis	
☐ Other: _____	

Childhood Diseases

	Year:
☐ Chicken Pox	
☐ Measles	
☐ Mumps	
☐ Polio	
☐ Other: _____	

Gynecological History (women only)

Last Menstrual Period	
How many pregnancies have you had?	
How many children do you have?	
Have you ever had an abnormal pap smear?	
Have you had a hysterectomy?	
Have your ovaries been removed?	

Sexual History

Do you have sex with: ☐ Men ☐ Women ☐ Both

Have you had an HIV Test? ☐ Yes ☐ No

Do you use condoms for sexual intercourse? ☐ Yes ☐ No

FAMILY HISTORY

Do you have any family history of serious illness? ☐ Yes ☐ No

If yes, list below:

	Mother	Father	Grandparent
Alcoholism	☐	☐	☐
Asthma	☐	☐	☐
Bleeding Problems	☐	☐	☐
Cancer, Type: _____	☐	☐	☐
Diabetes	☐	☐	☐
Emphysema	☐	☐	☐
Glaucoma	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Mental Illness/Suicide	☐	☐	☐
Osteoporosis	☐	☐	☐
Seizures	☐	☐	☐
Stroke	☐	☐	☐
Thyroid	☐	☐	☐

	Living Age	Deceased Age at Death and Cause
Father		
Mother		
Brother		
Sister		
Son		
Daughter		

PATIENT LABEL

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HEALTH MAINTENANCE

When did you last have any of the following?

Diabetes Check	_____	Pap Smear	_____
Prostate Check	_____	Cholesterol Check	_____
Colonoscopy	_____	Cardiac Stress Test	_____
Mammogram	_____	Bone Density	_____

List year of Last Vaccinations:

Tetanus (TD)	_____	Hepatitis A	_____
Influenza (Flu)	_____	Hepatitis B	_____
Pneumonia	_____	HPV	_____
Shingles (VZV)	_____	TB Skin Test	_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Co-habiting ☐ Separated ☐ Divorced ☐ Widowed

Do you have children/dependents at home? ☐ Yes ☐ No How many? _____

Are you employed? ☐ Yes ☐ No Occupation: _____

What is your highest level of education? ☐ High School ☐ College ☐ Graduate School

Do you or have you ever smoked or chewed tobacco? ☐ Yes ☐ No When? _____ Quit Date: _____
☐ Packs/☐ Cans/☐ Bags per day: _____ / years: _____

Do you or have you ever used recreational drugs? ☐ Yes ☐ No Type: _____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No Type: _____ How often? _____
How much per day? _____ / _____ years

Have you ever been exposed to toxic substances? ☐ Yes ☐ No Type: _____ What kind? _____

Do you drink caffeine? ☐ Yes ☐ No Type: _____ How often? _____

Do you exercise? ☐ Yes ☐ No Type: _____ How often? _____

Do you wear a seatbelt? ☐ Yes ☐ No

Do you use car seats for your children if under 60 lbs.? ☐ Yes ☐ No

Do you have a living will or advance directives? ☐ Yes ☐ No

Patient/Legal Representative Signature: _____ **Date/Time:** _____

If singed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

PATIENT LABEL