Plus One MEDICAL CLINIC

STAT Care PLUS™

Patient History Form

Date: _____

Name: _____ D.O.B. _____

Past Medical History: *(check all that apply)*

- ☐ Acid Reflux
- ☐ Alcohol or Drug Problem
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery/Vein problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ BPH
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ COPD
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Crohns
- ☐ Cholesterol
- ☐ Chronic pain
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Esophagitis, ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease / MI
- ☐ Heart Valve problems
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable bowel
- ☐ Kidney Disease
- ☐ Kidney stones
- ☐ Liver disease/Hepatitis
- ☐ Lung disease
- ☐ Migraines
- ☐ Mental Health Diagnosis
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid diseases

Other diseases not listed above: _____

Hospitalizations/Significant injuries: _____

_____

Surgery/Procedures History: *(check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal surgery
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete ☐ Partial
- ☐ Hernia
- ☐ Joint replacement/Orthopedic surgery
- ☐ Kidney surgery
- ☐ Organ Transplant
- ☐ Prostate surgery
- ☐ Thyroidectomy
- ☐ Sinus surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

Other surgery not listed above: _____

☐ Previous reaction to anesthesia: (explain) _____

_____

Please list the names of other practitioners you have or are currently seeing: _____

_____

Patient Name: _____

D.O.B. _____

Medication List:

Please list **all** prescription and non-prescription medications. This includes vitamins, herbal mediciine, supplements, birth control pills, inhalers and over the counter medications.

Medication	Dosage	How often	Disease or Reason	Prescribed by

List all medication you have stopped taking in the last 12 months: _____

_____

_____

Allergies or reactions:

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
1.		2.	
3.		4.	
5.		6.	

Preferred Pharmacy: _____

Patient Name: _____

D.O.B. _____

Name: _____

Family History:

Family Member	Age(s)	Living Y/N	If Deceased - Cause of Death	Age(s) at Death

Diseases in the family: *(check all that apply)*

- ☐ Arthritis
- ☐ Addiction problems
- ☐ Bleeding problems
- ☐ Cancer
  - ☐ Breast
  - ☐ Colon
  - ☐ Prostate
  - ☐ Other
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental Illness

Social History:

Do you live: ☐ Alone ☐ With Spouse or Partner ☐ With Family ☐ Other

Who do you rely on for support and help? _____

Do you smoke? ☐ Currently ☐ Past ☐ Never _____ pack/day for _____ years Date quit: _____

If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use? ☐ YES ☐ NO

Exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? _____

How many caffeinated beverages per day? _____ ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Any recreational drug use? ☐ YES ☐ NO

Type: _____

Do you exercise regularly? ☐ YES ☐ NO If so, how may times per week? _____ Type of exercise: _____

Do you feel safe in your home? ☐ YES ☐ NO

How many hours of sleep do you get per night? _____ Do you wake feeling well rested? ☐ YES ☐ NO

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D.O.B. _____

Preventative Care:

Date of last Colon and Rectal Screening: _____

Have you had a bone density (DEXA) exam? ☐ YES ☐ NO Date: _____

Date of last eye exam: _____ Date of last dental exam: _____

Immunization	Date	Immunization	Date
DT/DTaP/Td/Tdap		Hepatitis A	
HPV		Hepatitis B	
MMR		Influenza Vaccine	
HIB		Rotavirus	
Shingles		Varicella	
COVID (circle name) Moderna Pfizer Johnson & Johnson		Pneumococcal 13 Pneumococcal 23	
		Meningococcal	

For our FEMALE patients only:

Date of last menstrual period: _____

Do you have a Gynecologist ☐ YES ☐ NO If yes, Gynecologist name:

Date of last PAP test: _____ Date of last mammogram: _____

Have you gone through menopause: ☐ YES ☐ NO

Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____

Number of pregnancies: _____ Number of live births: _____ Current birth control method: _____

For our MALE patients only: Date of last PSA test: _____ Date of last rectal exam: _____

For our Pediatric patients only:

What is the current marital status of the child's parents?

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Widower

Who does the child primarily reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Other: _____

Does the child have siblings? ☐ YES ☐ NO If yes, # of brothers _____ # of sisters _____

Does the child attend daycare: ☐ YES ☐ NO If yes, average # of days per week _____

If school age, current grade in school: _____