Patient Name:_____

AXISHealth System

PATIENT HISTORY (*PLEASE COMPLETE ALL PAGES*)

Your answers on this form will help your healthcare team obtain an accurate history of you or your child's medical concerns and conditions. Please do your best to complete all three pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Current Healthcare Provider		
Do you have a previous Primary Care Provider?	☐ Yes ☐ No (check one)	*If Yes – please list:*
Do you have a Dentist?	☐ Yes ☐ No (check one)	*If Yes – please list:*

Allergies:

Source: (medications, pollens, food, animals, other)	Type of reaction:

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

Preferred Pharmacy:_____

Health Maintenance:	Yes	No
Dental visit in the past year?		
Vision check in the past year?		
Medical Provider visit this year?		

Immunizations:

Please check off any vaccinations you have had and list the year if known.

Vaccination:	Year:	Vaccination:	Year:
Flu Shot		Pneumonia (P13, P23)	
Hepatitis A		Shingles (Shingrex, Zostanax)	
Hepatitis B		Tetanus	
HPV		Tetanus w/ Pertussis (DTAP, TDAP)	
MMR		Varicella (Chicken Pox) Shot	
Polio		H. Influenza	
Meningitis		Other:	

Hospitalization and Surgical History (include psychiatric):

Reason:	Date	Location	Overnight Stay?

Patient Name:_____

AXISHealth System

Have you had any of the following screening tests?

Screening test/Other test	Completed/Obtained?	Date	Location	Result (*please circle*)
Colonoscopy Need results to scan to chart	Yes or No			Normal ☐ Abnormal ☐
Dexa (Bone Density) **Scan**	Yes or No			Normal ☐ Abnormal ☐
Heart tests: Catheterization, stress test, echo	Yes or No			Normal ☐ Abnormal ☐
Hepatitis B and C	Yes or No			Normal ☐ Abnormal ☐
HIV	Yes or No			Normal ☐ Abnormal ☐
Mammogram *We will need results for chart*	Yes or No			Normal ☐ Abnormal ☐
Pap *We will need results for chart*	Yes or No			Normal ☐ Abnormal ☐

Past and Current Medical Conditions: Please indicate with an **X** if you have had the following:

	Skin Condition		**Neurology**
	Eczema/Psoriasis		Migraine or headaches
	Eyes/Ears		Seizures
	Blindness		Traumatic brain injury / concussion
	Hearing Loss		Developmental Delay
	Respiratory		**Gastrointestinal**
	Asthma		Irritable bowel / Ulcerative colitis / Crohn's
	Pneumonia		**Musculoskeletal**
	Cardiovascular		Back/neck injury
	Hypertension		Arthritis
	High cholesterol		**Urological/Renal**
	Heart disease		Kidney Stones
	Endocrinology		Chronic kidney disease
	Diabetes Type 1		Frequent Urinary Tract Infection
	Diabetes Type 2		**Emotional / Behavioral**
	Thyroid Problems		ADHD
	Blood Conditions		Learning Disability
	Anemia		Depression
	Bleeding / clotting problems		Alcohol or Drug Abuse
	Other:		Anxiety

Family History: Please indicate with an X if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Heart Disease				
High Blood Pressure				
Cancer (Breast, Ovarian, Colon, Prostate)				
Diabetes				
Glaucoma				
Mental Illness				
Stroke				

Patient Name:_____

AXISHealth System

Birth History: Please complete for all patients up to age 12		**Yes**	**No**
Did birth mother have complications with pregnancy (GDM, Preeclampsia, Infection, Preterm labor, etc.)?			
Vaginal Delivery?			
C-Section?			
Newborn complications (Low birth weight, Hearing issues, Newborn Screening)?			
Gestational age at birth (weeks):	Maternal age:		

Social Determinants of Health:

Work Life

Retired/Unemployed/Leave of Absence/Disabled/Work from home. (Circle One)

Job:_____

Employer:_____

Years of education or highest degree:_____

Are you currently in school? ☐ Yes ☐ No

If YES: Grade:_____Course of Study:_____

Home Life

Spouse/Partner's Name:_____Number of Children:_____Ages if under 18:_____

Who lives at home with you?_____

Do you have pets? ☐ YES ☐ NO *If YES, please list*: _____

Leisure activities, group involvement, religion, volunteer work, recent travel, other interests:_____

Sexual Activity

Sexually Active (check box): ☐ Yes ☐ No ☐ Prefer not to discuss

Sexual partner(s) is/are/have been (please check box): ☐ Female ☐ Male ☐ Prefer not to discuss

Birth Control Method (circle all that apply): Condom, Pill, Diaphragm, Other:_____

Number of sexual partners in the past year? _____

Lifestyle Information: Tobacco Use

Smoking Status (*check one*):

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Use Details:

Quit date:_____How many years did you smoke:_____How many packs/day did you?_____

Current Smoker: Pack/Day:_____# of Years:_____

Other tobacco (please check all that apply): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ E-Cigarettes

Have you attempted to quit (check one): ☐ Yes ☐ No

If Yes, what have you used to try to quit? _____

_____

Alternative Treatments:

☐ Acupuncture ☐ Medical Marijuana ☐ Massage

☐ Naturopathic Remedies ☐ Other:

Within the past 12 months, we worried whether our food would run out before we got money to buy more:

☐ Often true ☐ Sometimes true ☐ Rarely true ☐ Never true

Within the past 12 months, the food we bought didn't last and we didn't have money to get more:

☐ Often true ☐ Sometimes true ☐ Rarely true ☐ Never true