CORECARE

Patient Medical History

Today's Date: _____

Patient information

Patient Name	Date of Birth	Sex
		☐ M ☐ F

Patient History

INDICATE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

- ☐ Head/brain injuries or illnesses (e.g., concussion)
- ☐ Seizures, epilepsy
- ☐ Eye problems (except glasses or contacts)
- ☐ Ear and or hearing problems
- ☐ Heart disease, heart attack, bypass, or other heart problems
- ☐ Pacemaker, stents, implantable devices, or other heart procedures
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Chronic (long-term) cough, shortness of breath or other breathing problems
- ☐ Lung disease (e.g., asthma)
- ☐ Kidney problems, kidney stones, or problems with urination
- ☐ Stomach, liver or digestive problems
- ☐ Diabetes or blood sugar problems
- ☐ Anxiety, depression, nervousness, or other mental health problems
- ☐ Fainting or passing out
- ☐ Dizziness, headaches, numbness, tingling, or memory loss
- ☐ Unexplained weight loss
- ☐ Stroke, mini-stroke (TIA), paralysis, or weakness
- ☐ Neck or back problems
- ☐ Bone, muscle, joint or nerve problems
- ☐ Blood clots or bleeding problems
- ☐ Cancer
- ☐ Chronic (long term) infection or other chronic diseases
- ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring

Allergies (include medication, food, latex and environmental allergies)

No known allergies ☐

Allergy to:			
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:			

Current Medication (include non-prescription products)

No current medications ☐

1.	3.	5.	7.
2.	4.	6.	8.

Preferred Pharmacy

Are you interested in using the Doctors Care in-center pharmacy? ☐ Yes ☐ No

Pharmacy Name	Pharmacy Location

Procedures / Surgeries

No procedures or surgeries ☐

Surgery / Procedure #1	Approximate Date	Surgery / Procedure #3	Approximate Date
Surgery / Procedure #2	Approximate Date	Surgery / Procedure #4	Approximate Date

CORECARE

Patient Medical History – Pg. 2

Preventative Screening

Not applicable ☐

Have you had a colonoscopy?	☐ Yes ☐ No	If yes, date:
Have you had a mammogram?	☐ Yes ☐ No	If yes, date:

Women's Health

Not applicable ☐

When was your most recent menstrual cycle? Date:

Family History

Mother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Father	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Sister	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Brother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A

Other Health Issues

Do you drink alcohol?	☐ Yes ☐ No	☐ Beer ☐ Wine ☐ Liquor _____ per week
Do you smoke cigarettes?	☐ Yes ☐ No	If yes, _____ per day, _____ years of use
Do you use other forms of tobacco?	☐ Yes ☐ No	☐ Pipe ☐ Cigar ☐ Snuff/Chew
Do you vape or use an e-cigarette?	☐ Yes ☐ No	If yes, _____ per day, _____ years of use
Marijuana / recreational drug use?	☐ Yes ☐ No	If yes, _____ per day, _____ years of use

Immunizations

Influenza (18 years of age and older)	☐ Yes ☐ No	If yes, date: _____
Pneumoccal (65 years of age and older)	☐ Yes ☐ No	If yes, date: _____
Tetanus	☐ Yes ☐ No	If yes, date: _____
COVID-19	☐ Yes ☐ No	Number of shots: _____ Date of most recent: _____