Commonwealth Primary Care, Inc.
Patient History

Today's Date: _____

Physician/Location: ☐ Glen Forest ☐ Ridgefield ☐ Wyndham ☐ RPC ☐ Huguenot
☐ Sommerville ☐ VFP ☐ West Creek ☐ Commonwealth Extended Care

Patient Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Phone Number: (home) _____ (work) _____ (mobile) _____

Best number to reach you? _____

Past Medical History
Check any illnesses or conditions you have had:

☐ Anemia	☐ Depression	☐ Heart disease	☐ Nervous disorder	☐ Thyroid
☐ Anxiety	☐ Diabetes	☐ High blood pressure	☐ Pneumonia	☐ Tuberculosis
☐ Asthma/Bronchitis	☐ Emphysema	☐ Jaundice/Liver Problems	☐ STD's	☐ Other:_____
☐ Bleeding tendency	☐ Epilepsy	☐ Kidney problems	☐ Stroke	_____
☐ Cancer_____	☐ Glaucoma	☐ Migraines	☐ Substance Abuse	_____

Past Surgical History
Check any past surgeries you have had:

☐ Appendectomy	☐ Coronary Stent	☐ Kidney Surgery	☐ Wisdom Teeth
☐ Carotid Endarterectomy	☐ C-Section	☐ Lap band	☐ Other:_____
☐ Cholecystectomy	☐ Gastric Bypass	☐ Orthopedic	_____
☐ Colon Surgery	☐ Hysterectomy	☐ Tonsillectomy	_____
☐ Coronary Artery Bypass Graft (CABG)			

Date of Last **Colonoscopy**: __/__/____ Date of Last **DEXA**: __/__/___ Date of Last **Eye Exam**: ___/___/_____

Please list current **MEDICATIONS** with dosing (including nonprescription meds, vitamins, and supplements):

_____

_____

_____

Please list any **ALLERGIES** to medications, latex, or any other substances:

_____

_____

_____

Family History
Check illnesses which have occurred in any of your BLOOD RELATIVES:

	Family Member	Type		Family Member
☐ Allergy	_____	_____	☐ Bleeding tendency	_____
☐ Cancer	_____	_____	☐ Diabetes	_____
☐ Heart disease	_____		☐ High blood pressure	_____
☐ Kidney disease	_____		☐ Nervous illness	_____
☐ Tuberculosis	_____		☐ Other	_____

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Reproductive History (if applicable)

Onset of last menstrual cycle: _____ Periods are: ☐ Regular ☐ Irregular ☐ Other:_____

Number of pregnancies: _____ Number of miscarriages: ____ Current contraceptive: _____

Date of Last **Mammogram**: __/__/____ Date of Last **Pap Smear**: __/__/____

Social History (if applicable**)**

Occupation: _____ How long: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you Exercise? ☐ yes ☐ no #:_____ per Day / Week / Month

Do you use: Tobacco: ☐ yes ☐ no #/day:_____ years of use_____
Alcohol: ☐ yes ☐ no #/day:_____ years of use_____
Caffeine: ☐ yes ☐ no #/day:_____ years of use_____
Illegal Drugs: ☐ yes ☐ no #/day:_____ years of use_____

Education Level: _____

Where and When have you lived or traveled outside of the U.S. or Canada:_____

_____

Mother: ☐ Living ☐ Deceased
Father: ☐ Living ☐ Deceased
Brothers: # Living ____ # Deceased _____
Sisters: # Living ____ # Deceased _____

Do you have any children? ☐ yes ☐ no

If yes, please list date of birth, age, and gender: _____

_____

_____

Check the disease against which you have been immunized. Please list the most current immunization date and location.

☐ Smallpox _____
☐ Tetanus _____
☐ Typhoid _____
☐ Polio _____
☐ Influenza _____
☐ Pneumonia _____
☐ Pneumovax _____
☐ Prevnar _____
☐ Other:_____
_____