Christ Community
HEALTH SERVICES, AUGUSTA, GEORGIA

Patient History Form *Today's Date*__________________

Name ______________________________ DOB ___________ SSN ________________________________

Reason for visit: ____

____

All Current medications and doses: ____

____

____

Medical History (check all that apply)

☐ Heart Problems ☐ High Blood Pressure ☐ High Cholesterol ☐ Cancer

☐ Depression/Anxiety ☐ Lung Problems ☐ Kidney Problems ☐ Thyroid Problems

☐ Other: ____

Drug Allergies: ____

____

Surgeries

Date_____ Reason _________________________ Date_____ Reason _________________________

Date_____ Reason _________________________ Date_____ Reason _________________________

Hospitalizations

Date_____ Reason _________________________ Date_____ Reason _________________________

Date_____ Reason _________________________ Date_____ Reason _________________________

What Pharmacy do you use? __________________________________ **Phone**_______________________

Name ________________________________

Have you ever had...

1. a colonoscopy? Yes / No When?__________ Where?____________________________
2. a pap smear? Yes / No When?__________ Where?____________________________
3. a mammogram? Yes / No When?__________ Where?____________________________
4. a PSA (prostate screen)? Yes / No When?__________ Where?____________________________
5. a DXA (bone density test)? Yes / No When?__________ Where?____________________________
6. a pneumonia shot? Yes / No When?__________ Where?____________________________

Do you or your family have a history of: (List WHO in your family has this history...)

1. Cancer?____
2. High Cholesterol? ____
3. Diabetes?____
4. Heart Attack?____
5. Other Heart Problems? ____
6. Stroke?____
7. Colon/Prostate Cancer? ____
8. Osteoporosis? ____
9. Anxiety/Depression? ____
10. Psychiatric Problems?____
11. Drug/Alcohol Problems? ____
12. High Blood Pressure? ____

Social History

1. Are you or have you ever been a smoker? Yes / No how often?________________________________
2. Do you drink alcohol? Yes / No how often?________________________________
3. Do you use any drugs? Yes / No how often/ which?__________________________
4. Marital status: Single/ Engaged/ Married/ Separated/ Divorced/ Widowed
5. Occupation: ____
6. Do you exercise? Yes / No how often?________________________________
7. Do you drink caffeine? Yes / No how often?________________________________
8. Do you have any pets Yes / No type:_____________________________________
9. Do you have a smoke detector? Yes / No
10. What is your faith background? Buddhist__ Christian (Catholic, Orthodox, Protestant) Hindu __ Jewish__ Muslim__ None__ Other __
11. (If relevant)Where do you regularly worship? ______________________________________

List all Physicians or Clinics or ERs you have visited in the last 6 months:

Date________________ **MD/Clinic**____________________ **Reason**__________________________________
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