NORTHSIDE
DAHLONEGA
PRIMARY CARE
A Northside Network Provider

MEDICAL HISTORY - Page 1

Please take a few minutes to fill out our health history form. PLEASE fill in all areas, **FRONT** AND **BACK**, BEFORE YOUR APPOINTMENT. Your answers will help the provider plan and provide your care.

Name:______________________________ DOB: ___/___/_____ Today's Date: ___/___/_____

Pharmacy: ______________________________ Pharmacy Location: ______________________________

ADVANCE DIRECTIVES: *Please check (✓) all that apply*

Do you have a Power of Attorney for health care? ☐ No ☐ Yes-Designated Individual:
Do you have a living will/Do not resuscitate? ☐ No ☐ Yes
Are you an organ donor? ☐ No ☐ Yes

Patient Care Team: *Please list all doctors/specialists you see (use additional sheets of paper if needed)*

Specialty:	Name/Group:	Last Visit Date:	Specialty:	Name/Group:	Last Visit Date:

CURRENT MEDICAL HISTORY: *Please check (✓) all that apply*

- ☐ Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrilla
- ☐ Bipolar
- ☐ Colon Disease
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Enlarged Prostate
- ☐ Genetic Disease or Trait
- ☐ Reflux/GERD
- ☐ Blood Clot
- ☐ Heart Attack (MI)
- ☐ Other Heart Disease
- ☐ Hepatitis _______
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High BP)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pulmonary Embolism
- ☐ Schizophrenia
- ☐ Seizures/Epilepsy
- ☐ Skin Disease
- ☐ TIA/CVA (Stroke)
- ☐ Thyroid Disease

Are you currently under treatment/s for Cancer?

☐ No ☐ Yes TYPE: __________

☐ Other Mental Illness:

☐ Other: __________

HOSPITALIZATIONS/SURGERIES: *Please check (✓) all that apply*

- ☐ Appendectomy
- ☐ Coronary Artery Bypass (Open Heart)
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ Cholecystectomy (Gallbladder)
- ☐ Bariatric - (Gastric Bypass, Lao Banding)
- ☐ Hysterectomy (Partial or Total)
- ☐ Nephrectomy
- ☐ Splenectomy
- ☐ Tonsillectomy, Adenoidectomy
- ☐ COPD/Emphysema
- ☐ Orthopedic Surgeries:

Other: __________

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MEDICAL HISTORY - Page 2

Name:________________________________ DOB: ___/___/_____

FAMILY HISTORY: *Please check &/or list all family members that apply*

Illness	Relation to you
☐ Alcoholism	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Anemia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Asthma	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Blood Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Cancer (what kind?) ____________	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Cerebral Infarction (Stroke)	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Dementia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Diabetes	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Genetic Disease (sickle cell, cystic fibrosis, brca)	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Heart Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Hyperlipidemia (High Cholesterol)	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Hypertension (High Blood Pressure)	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Kidney Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Mental Illness	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Osteoporosis	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Hear Attack < 50 yrs	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Seizures/Epilepsy	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Thyroid Problems	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:
☐ Other:	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Other:

SOCIAL HISTORY: *Please check &/or answer each question*

Tobacco Use:	☐ Current ☐ Former (Quit Year ______) ☐ Never ☐ Exposure to Smoke ☐ E-Cigs ☐ Other ________
Alcohol Use:	☐ Never drink ☐ Occasional/social drinker ☐ _____ # of drinks/day of alcohol
Drug Use:	☐ None ☐ Other use ____________
Caffeine Use:	☐ No ☐ Yes – How much?____________
Exercise:	☐ Sedentary ☐ Light ☐ Moderate
Marital Status:	☐ Married ☐ Divorced ☐ Widowed ☐ Single # of Children? _____ # of Grandchildren? _____ | Spouse's Name:____________
Living Arrangements:	☐ Independent– ☐ Alone or ☐ With Others ☐ Nursing Home ☐ Assisted Living Facility ☐ With Caregiver(s)
Employment:	Current Job/Occupation? ____________ Prior Occupation____________
Sexually Active:	☐ No ☐ Yes – with ☐ Male ☐ Female ☐ Both # of sexual partners

WOMENS HEALTH HISTORY: *Please check &/or answer each question*

Age of first period: _____ yrs old	Has menopause started/occurred? ☐ No ☐ Yes– at age _____ yrs
Number of days between periods: _____ Number of days period lasts: _____ Flow is: ☐ light ☐ moderate ☐ heavy	
Number of: Total pregnancies: _____ Full term births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____	Number of: Vaginal Births: _____ C-section: _____
Birth Control: ☐ None ☐ Birth control pill ☐ DepoProvera ☐ IUD ☐ Partner-Vasectomy ☐ Other ____________	

MENS HEALTH

Last Prostate Exam:____________	Last Rectal Exam:____________

MEDICAL HISTORY - Page 3

Name:______________________________ DOB: ___/___/_____

ALLERGIES: List all *allergies* and *the type of reaction* (Ex: Sulfa-rash, Codeine- nausea, etc.)

Allergies	Type of Reactions
1.	
2.	
3.	
4.	

Use additional blank pages if needed

CURRENT MEDICATIONS: *List all medications*

Medicine	Over the Counter Vitamins/Supplements	Dosage	How often?	Provider
Ex: Lasix		**20 mg**	**Twice a day**	**Dr. Jones**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

(Use additional blank pages if needed and attach them please)

Immuniztions: *Please check (✓) all that apply* *** **Please bring in a copy of your immunization records*****

Adult Vaccines: ☐ Tetanus ☐ Pneumonia ☐ Flu Shot ☐ Hep B ☐ Shingles ☐ Covid ☐ Other: ____________

PREVENTATIVE CARE: *Please list the dates of your last test and results if known*

Test	Date	Results
Mammogram		
Pap smear		
Colonoscopy		
AAA Screening (Abdominal Aortic Aneurysm)		

☐ PSA Last Done ____________

☐ Cholesterol Last Done ____________

☐ A1C, Average Blood Sugar ____________

☐ Thyroid Labs When: ____________

DEPRESSION SCREENING:

Over the past two weeks, I have had little interest or pleasure in doing things: ☐ No ☐ Yes
Over the past two weeks I have felt down, depressed or hopeless: ☐ No ☐ Yes

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MEDICAL HISTORY - Page 4

Name:______________________________ DOB: ___/___/_____

REVIEW OF SYSTEMS: Check all that you are *currently* experiencing.

☐ Feeling Tired or Poorly	☐ Red Blood in Bowel Movement
☐ Fever	☐ Diarrhea
☐ Chills	☐ Constipation
☐ Headache	☐ Blood in Urine
☐ Sinus Pain	☐ Urinating frequently
☐ Neck Symptoms	☐ Urinary Loss of Control
☐ Vision Problems	☐ Pain During Urination
☐ Earache	☐ Pain in Flank
☐ Nasal Symptoms	☐ Vaginal Discharge
☐ Sore throat	☐ Musculoskeletal Symptoms
☐ Chest pains or Discomfort	☐ Soft Tissue Swelling
☐ Palpitations	☐ Motor Disturbances
☐ Difficulty Breathing	☐ Sensory Disturbances
☐ Cough	☐ Anxiety
☐ Wheezing	☐ Depression
☐ Heartburn	☐ Insomnia
☐ Nausea	☐ Skin lesion
☐ Vomiting	☐ Tarry or Black Stool
☐ Abdominal pain	

Additional information you would like to share with the provider:

MEDICAL HISTORY