

☐ BENTON FAMILY HEALTH CARE CTR 6784 Hwy 411 Benton, TN 37307	☐ BLED SOE COUNTY PRMAY CARE CTR 3625 Main St. Pikeville, TN 37367	☐ CLEVELAND FAMILY HEALTH CARE CENTER 2020 Westland DR. Cleveland, TN 37323	☐ GRUNDY COUNTY PRIMARY CARE CTR 10120 State Route 56 Coalmont, TN 37313	☐ MEIGS COUNTY PRIMARY CARE CTR 305 River Rd. Decatur, TN 37322	☐ RHEA COUNTY PRIMARY CARE CTR 8850 Rhea County Hwy Dayton, TN 37321
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FULL NAME: _____ **DATE:** _____ **DATE OF BIRTH:** _____

FIRST MIDDLE LAST

DRUGS OR OTHER ALLERGIES: _____

PAST MEDICAL HISTORY: *(PLEASE CHECK ANY THAT APPLY TO YOU)*

- | | | | |
|---|---|---|---|
| ☐ ALLERGIES | ☐ BLOOD CLOTS | ☐ GALLBLADDER DISEASE | ☐ HEART ATTACK (M.I.) |
| ☐ ANEMIA | ☐ CANCER: _____ | ☐ GERD | ☐ OSTEOARTHRITIS |
| ☐ ANGINA | ☐ CEREBROVASCULAR ACCIDENT | ☐ HEPATITIS C | ☐ OSTEOPOROSIS |
| ☐ ANXIETY | (STROKE) | ☐ HYPERLIPIDEMIA | ☐ PEPTIC ULCER DISEASE |
| ☐ ARTHRITIS | ☐ COPD | (HIGH CHOLESTEROL) | ☐ RENAL DISEASE |
| ☐ ASTHMA | ☐ CORONARY ARTERY DISEASE | ☐ HYPERTENSION | ☐ SEIZURE DISORDER |
| ☐ ATRIAL FIBRILATION | ☐ CROHN’S DISEASE | ☐ IRRITABLE BOWL DISEASE | ☐ THYROID DISEASE |
| ☐ BENIGN PROSTATIC | ☐ DEPRESSION | ☐ LIVER DISEASE | ☐ OTHER _____ |
| HYPERTROPHY | ☐ DIABETES | ☐ MIGRAINE HEADACHES | |

PAST SURGICAL HISTORY: *PLEASE FILL IN THE YEAR OF ANY SURGERIES YOU HAVE HAD*

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
ANGIOPLASTY		COLECTOMY		PACEMAKER	
ANGIO WITH STENT		COLOSTOMY		SMALL BOWEL RESECTION	
APPENDECTOMY		GASTRIC BYPASS		THYROIDECTOMY	
ARTHROSCOPY (KNEE)		HERNIA REPAIR		TONSILLECTOMY	
BACK SURGERY		HIP REPLACEMENT		PROSTATE BIOPSY	
CABG		KNEE REPLACEMENT		PROSTATE RESECTION	
CARPAL TUNNEL		LASIK		VASECTOMY	
CATARACT		LIVER BIOPSY		OTHER:	
GALL BLADDER REMOVED		O.R.I.F. (FRACTURE REPAIRED SURGICALLY)		OTHER:	

PAST DIAGNOSTIC HISTORY: *LIST PREVIOUS DIAGNOSTIC STUDIES/TESTS? (example: mammogram, CT, MRI, x-ray, ultrasound, etc.)*

TEST	DATE	RESULT	COMMENT

FAMILY HISTORY: CHECK THEN INDICATE FAMILY MEMBER: *MOTHER / FATHER / SISTER / BROTHER / OTHER RELATIVE*

DISEASE/DISORDER:	FAMILY MEMBER:	DISEASE/DISORDER:	FAMILY MEMBER:
☐ ADD/ADHD		☐ HEARING PROBLEMS	
☐ ALCOHOLISM		☐ HIGH CHOLESTEROL	
☐ ALLERGIES		☐ HIGH BLOOD PRESSURE	
☐ ALZHEIMER’S DISEASE		☐ IRRITABLE BOWEL	
☐ ASTHMA		☐ LEARNING DISABILITY	
☐ BLOOD DISEASE		☐ MENTAL ILLNESS	
☐ CAD (CORONARY ARTERY DISEASE)		☐ MIGRAINES	
☐ PREMATURE CAD		☐ OBESITY	
☐ CANCER: _____		☐ OSTEOARTHRITIS	
☐ CVA/STROKE		☐ PVD(PERIIPHERAL VASCULAR DISEASE)	
☐ DEPRESSION		☐ KIDNEY DISEASE	
☐ DEVELOPMENTAL DELAY		☐ SEIZURE DISORDER	
☐ DIABETES		☐ OTHER:	
☐ ECZEMA			

SOCIAL HISTORY:

PRIMARY LANGUAGE: _____

COUNTRY OF BIRTH: _____

HAND DOMINANCE: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS**EDUCATION/EMPLOYMENT/OCCUPATION/MILITARY:**

LAST GRADE COMPLETED OR DEGREE OBTAINED: _____

EMPLOYER: _____ ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ UNEMPLOYED

OCCUPATION: _____ RESTRICTIONS: _____

MILITARY EXPERIENCE? ☐ NO ☐ YES

MARITAL STATUS: _____

PREVIOUSLY WIDOWED? ☐ NO ☐ YES PREVIOUSLY DIVORCED? ☐ NO ☐ YES HAVE CHILDREN? ☐ NO ☐ YESHOUSING STATUS: ☐ STABLE/PERMANENT ☐ TEMPORARY ☐ UNSTABLE

WHO DO YOU LIVE WITH? _____

TOBACCO USE: ☐ NEVER ☐ FORMER ☐ CURRENT**TYPE:** ☐ CHEWING ☐ CIGAR ☐ CIGARETTES ☐ PIPE ☐ SMOKELESS ☐ SNUFFQUANTITY: _____ YEARS USED: _____ PASSIVE SMOKE EXPOSURE? ☐ NO ☐ YES**ALCOHOL USE:** DO YOU DRINK ALCOHOL? ☐ NO ☐ YES

TYPE: _____ FREQUENCY: _____ AMOUNT: _____ WHEN WAS YOUR LAST DRINK: _____

CAFFIENE: DO YOU CONSUME CAFFEINE? ☐ NO ☐ YES**RELIGIOUS / SPIRITUAL:**DO YOU HAVE A RELIGIOUS AFFILIATION? ☐ NO ☐ YES RELIGION: _____DO YOU ACCEPT BLOOD TRANSFUSIONS? ☐ NO ☐ YES**HOME ENVIRONMENT/SAFETY:**SMOKE DETECTORS IN HOME? ☐ NO ☐ YESCARBON MONOXIDE DETECTOR IN HOME? ☐ NO ☐ YESANY FALLS IN THE LAST YEAR? ☐ NO ☐ YESRADON IN HOME? ☐ NO ☐ YESPOOL / SPA AT HOME? ☐ NO ☐ YES

TYPE OF HOME HEATING: _____

FIRE ARMS IN HOME? ☐ NO ☐ YESDO YOU USE A SEATBELT? ☐ NO ☐ YES**RECENT TRAVEL:**☐ OUT OF STATE ☐ OUT OF THE COUNTRY ☐ TRAVEL EXPOSURE? _____**IMMUNIZATIONS:** DATE OF LAST IMMUNIZATION

FLU _____ PNEUMONIA _____ TETANUS (DTP, DTAP) _____

HEP. A _____ HEP B _____ MMR _____

TB SKIN TEST _____

MEDICINES YOU ARE CURRENTLY TAKING: (LIST PRESCRIPTIONS AND OVER THE COUNTER, BIRTH CONTROL, VITAMINS, HERBS, ETC.)

NAME OF MEDICINE / DOSAGE	NAME OF MEDICINE / DOSAGE	NAME OF MEDICINE / DOSAGE