Gilbert Center
For Family Medicine

Patient Information

______________________ Name

_______/_______/_______ Birth Date

Medical History 1

Pharmacy

Primary ____________________________ **Cross Streets** ____________________________

Secondary or Mail Order ____________________________ **Cross Streets** ____________________________

Advanced Directives

Type

- □ None
- □ Living Will
- □ Refuse
- □ Do Not Place On Life Support
- □ Do Not Resuscitate
- □ Power of Attorney

Effective Date _____/_____/_____

Allergies

□ **No Allergies**

Please Specify Allergy & Reaction

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Medications

□ **No Medications**

Medication Name	Strength	Directions

Past Medical/Surgical History

□ **No Relevant History**

Past Medical History

	Year		Year		Year
□ Allergies	______	□ COPD	______	□ Liver Disease	______
□ Anemia	______	□ Coronary Artery Disease	______	□ Migraine Headaches	______
□ Angina	______	□ Crohn's Disease	______	□ Myocardial Infarction	______
□ Anxiety	______	□ Depression	______	□ Osteoarthritis	______
□ Arthritis	______	□ Diabetes	______	□ Osteoporosis	______
□ Asthma	______	□ Gallbladder Disease	______	□ Peptic Ulcer Disease	______
□ Atrial Fibrillation	______	□ GERD	______	□ Renal Disease	______
□ Benign Prostatic Hypertrophy	______	□ Hepatitis C	______	□ Seizure Disorder	______
□ Blood Clots	______	□ Hyperlipidemia	______	□ Thyroid Disease	______
□ Cancer *Type* ___________	______	□ Hypertension	______		
□ Cerebrovascular Accident	______	□ Irritable Bowel Disease	______		

Past Surgical History

	Year		Year	**Females Only**	Year
□ Angioplasty	______	□ Gastric Bypass	______	□ Augmentation Mammoplasty	______
□ Angio w/stent	______	□ Hernia Repair *Site* _______	______	□ Bilat. Tubal Ligation	______
□ Appendectomy	______	□ Hip Replacement *Side* ____	______	□ Breast Biopsy *Side* _______	______
□ Arthroscopy Knee *Side* ____	______	□ Knee Replacement	______	□ Cesarean Section	______
□ Back Surgery	______	□ Lasik	______	□ D and C	______
□ CABG	______	□ Liver Biopsy	______	□ Hysterectomy	______
□ Carpel Tunnel Release	______	□ ORIF	______	□ Mastectomy	______
□ Cataract Extraction *Side* __	______	□ Pacemaker	______	□ Myomectomy	______

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Medical History 2

☐ Cholecystectomy ______ ☐ Small Bowel Resection _______ ☐ Reduction Mammoplasty ______
☐ Colectomy ______ ☐ Thyroidectomy _______ ☐ TAH/BSO ______
☐ Colostomy ______ ☐ Tonsillectomy _______ ☐ Vaginal Hysterectomy ______

Additional History

________________________ ________________________________ _______
System **Disease** **Year**

________________________ ________________________________ _______
Management **Outcome** **Year**

Males Only **Year**
☐ Prostate Biopsy ______
☐ TURP ______
☐ Vasectomy ______

☐ **Patient Adopted** **Family History** ☐ **No Relevant History**

Diagnosis	**Family Member(s) Immediate Family/Blood Relatives *Please Specify Side Of Family (Mother or Father)***	**Age Onset**	**Death Cause**
ADD/ADHD			☐ Yes
Alcoholism			☐ Yes
Allergies			☐ Yes
Alzheimer's Disease			☐ Yes
Asthma			☐ Yes
Blood Disease			☐ Yes
CAD (Coronary Artery Disease)			☐ Yes
CAD - Premature			☐ Yes
Cancer *Type* __________			☐ Yes
CVA (Stroke)			☐ Yes
Depression			☐ Yes
Developmental Delay			☐ Yes
Diabetes			☐ Yes
Eczema			☐ Yes
Hearing Deficiency			☐ Yes
Hyperlipidemia			☐ Yes
Hypertension			☐ Yes
Irritable Bowel Disease			☐ Yes
Learning Disability			☐ Yes
Mental Illness			☐ Yes
Migraines			☐ Yes
Obesity			☐ Yes
Osteoarthritis			☐ Yes
Osteoporosis			☐ Yes
PVD			☐ Yes
Renal Disease			☐ Yes
Seizure Disorder			☐ Yes
Other_______________			☐ Yes

Social History

Statuses

Race
☐ African American/Black ☐ Caucasian/White ☐ Pacific Islander/Native Hawaiian
☐ American Indian/Alaska Native ☐ Hispanic/Latino ☐ Other
☐ Asian ☐ Middle Eastern ☐ Do Not Wish To Disclose

Ethnicity ☐ Hispanic/Latino Origin ☐ No Hispanic/Latino Origin ☐ Unknown

Primary Language Spoken ☐ English ☐ Spanish ☐ Other __________________

Language Spoken At Home ☐ English ☐ Spanish ☐ Other __________________

Country Of Birth ☐ USA ☐ Other ____________________

Hand Dominance ☐ Right ☐ Left ☐ Ambidextrous

Employer (Name) _________________________________

Occupation (Type Of Work) ________________________

Employment Status
☐ Full Time ☐ Self-Employed ☐ Retired *Date* ___/___/___
☐ Part Time ☐ Unemployed ☐ Other ______________

Work Restrictions
☐ avoid dust/fumes ☐ no heavy lifting
☐ no climbing ☐ Other ______________

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Medical History 3

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated ☐ Annulled ☐ Other _________

Previously Widowed ☐ No ☐ Yes

Previous Divorce ☐ No ☐ Yes

Has Children ☐ No ☐ Yes **Number of Sons** _______ **Number of Daughters** _______

Tobacco/Alcohol/Caffeine

Uses Tobacco ☐ Current ☐ Former ☐ Never ☐ Unknown

Tobacco Type ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ Smokeless ☐ Snuff

Units/Day ____________________
Years Used ____________________
Pack Years ____________________

Ever Tried To Quit? ☐ No ☐ Yes **Year Quit** __________ **Longest Tobacco Free** _____________________

Relapse Reason ___________________ **Passive Smoke Exposure** ☐ No ☐ Yes

Smoker Status ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker, Status Unknown ☐ Never Smoker ☐ Former Smoker ☐ Unknown If Ever Smoked

Drinks Alcohol ☐ No ☐ Yes ☐ Formerly **Caffeine** ☐ No ☐ Yes

Lifestyle – Other

Activity Level ☐ Moderate ☐ Sedentary ☐ Vigorous

Health Club Member ☐ Now ☐ Previously ☐ Never

Type Of Exercise ____

Exercise Frequency ___________________________________

Hours/Week ________________

Hobbies/Activities ____

Diet History ☐ Diabetic ☐ Vegan ☐ Vegetarian ☐ High Fiber ☐ Low Sodium ☐ High Protein ☐ Other

Animals In The Home ☐ No ☐ Yes *Type* ______________

Lifestyle – Home Environment/Safety ***(For Insurance Company Purposes)***

Smoke Detectors In Home ☐ No ☐ Yes **Pool/Spa At Home** ☐ No ☐ Yes

Carbon Monoxide Detectors In Home ☐ No ☐ Yes **Seat Belt Use** ☐ No ☐ Yes

Falls In The Last Year ☐ No ☐ Yes Number/Falls _________ **Home Heating Method** ☐ Gas ☐ Electric

Radon In The Home ☐ No ☐ Yes ☐ Treated ☐ Untested **Firearms At Home** ☐ No ☐ Yes ☐ No Answer

Disease Management

Health Maintenance

	Date		Date	**Females Only**	Date
☐ H&P (Physical Exam)	___/___/___	☐ Influenza Vaccine	___/___/___	☐ GYN Exam	___/___/___
☐ Lipid Panel	___/___/___	☐ Tdap Vaccine	___/___/___	☐ Breast Exam	___/___/___
☐ EKG	___/___/___			☐ Pap	___/___/___
☐ Colonoscopy	___/___/___	**Males Only**	**Date**	☐ Mammogram	___/___/___
☐ FOBT	___/___/___	☐ PSA	___/___/___	☐ Dexa Scan	___/___/___

******DIRECTIONS******

Our preferred method to receive forms is via email. Please send forms at least 24 hours prior to your appointment. Not having these in advance may delay your appointment time.

Email: **Save this PDF file to your computer after completion.**
Go to emailyourdoc.com for secure emailing.
Upload the file and email it to office@mdofficemail.com.

Fax: **(480) 539-1763.**

Hand Carry: **Bring a copy with you to your appointment (if possible) at least 24 hours prior.**