ROPER ST. FRANCIS PHYSICIAN PARTNERS

Name: _____

DOB: _____

Patient History

Thank You for choosing Roper St. Francis Physicians Partners –Primary Care. We look forward to developing a relationship with you and collaborating on your health care. In order to better serve you, please provide us with your medical history.

Preventive Health

Immunization	**Date Performed**		
Annual Lab (In the past year)			
Influenza Vaccination			
Prevnar (1st Pneumonia shot)			
Pneumovax(2nd Pneumonia shot)			
Tetanus Vaccination			
TDAP (Whooping cough)			
Zostavax (Shingles vaccine)			
Shingrix (Shingles vaccine)			
Screening Test	**Date Performed**	**Results** (Normal/Abnormal)	**Location**
Colonoscopy/Colon Screening			
Mammogram			
PAP (cervical cancer screen)			
PSA (Prostate)/DRE(rectal exam)			
Chest X-Ray			
Chest CT (Lung Scan)			
Dexa Scan (Bone Scan)			
Eye Exam			
Other:			

Medications

Please list all medications you are taking currently, including over the counter and herbal remedies. Please include dosage and number of times a day the medication is taken if known.

Medication Name:	**Dosage (mg, cc, etc)**	**Frequency (how often)**

Past Medical History

Please mark any current or previous illnesses or health problems.

☐ ADD/ADHD ☐ Dementia ☐ Kidney Stones

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- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Asbestos Exposure
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer (type)_____
- ☐ COPD/Emphysema
- ☐ Chronic Pain related ___ to _____
- ☐ Depression
- ☐ Degenerative Joint Disease
- ☐ Diabetes Mellitus
- ☐ Drug/Alcohol Addiction
- ☐ Female Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Rhythm Problem
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lung Problems
- ☐ Male Problems
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Sickle Cell
- ☐ Thyroid Disease
- ☐ Tuberculosis (positive PPD)
- ☐ Ulcers

Other History/Details _____

_____

_____

Allergies

Please list all food and drug allergies:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History / Major Diagnostic Procedures

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric (Weight Reduction)
- ☐ Breast (was cancer involved ☐)
- ☐ C-Section
- ☐ Gall Bladder
- ☐ Lung Biopsy
- ☐ Lung Resection
- ☐ Heart Catheterization
- ☐ Heart Bypass Surgery
- ☐ Prostate Surgery
- ☐ Hysterectomy (was cancer involved ☐)
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Tumor Removal
- ☐ Vasectomy

Other History/Details _____

_____

_____

Hospitalizations/Emergency Room Visits

Reason	Date

Social History

Have you ever smoked? (cigarettes, vape, cigars, etc.) ☐ No ☐ Yes

How many per day?_____How many years?_____Stop date_____

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week?_____

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Do you use any street drugs? ☐ No ☐ Yes If yes please list _____

Female Patients

Number of Pregnancies?	
Number of full term (>38wks) births?	
Number of premature births?	
Number of miscarriages or abortions?	
Number of living children?	

Family History

Are you adopted? ☐ Yes ☐ No

	Father	Mother	Siblings	Paternal GF	Paternal GM	Maternal GF	Maternal GM
Living							
Deceased							
Diabetes							
Hypertension							
Heart Disease							
Mental Illness							
Cancer (type)							
Stroke							
Thyroid Disease							
High Cholesterol							
Blood Clots							
Lung Disease							
Tuberculosis							
Mental Illness							
Headaches							
Seizure							
COPD/Emphysema							
Other (specify)							
Unknown							