Cornerstone Clinic Patient History Form

Thank you for partnering with Cornerstone Clinic for your health care.
Please take a few minutes to complete this summary of your health history.
Use the back of this form if you need more room.

NAME: _____ **Date of Birth:**_____

ALLERGIES: ***(Include drugs, foods, chemicals, insects, etc.)***

Medication or Other Item	Type of Reaction

MEDICATIONS: ***(Please list all medications that you take every day, including vitamins or herbal supplements, birth control, and over-the-counter products.)***

Medication Name	Dosage (strength and how many times per day)

HOSPITALIZATIONS ***(List overnight hospital stays)*:**

Reason for Hospital Stay	Date

FOR WOMEN:

Age at First Period:	Date of Last Period:
Number of Times Pregnant:	Date of Last Pap Smear:
Number of Babies Delivered:	Date of Last Mammogram:
Any Miscarriages or Abortions:	Date of Last Bone Density:

For Men and Women, date of last Colonoscopy: _____

IMMUNIZATIONS: ***(please enter last known date of immunization listed)***

Tetanus:	**Pneumonia:**
Influenza (Flu):	**Shingles:**

NAME: _____ **Date of Birth:**_____

PAST MEDICAL HISTORY: ***(Please circle any of these that apply to you, either now or in the past)***

Allergies	Arrhythmia	Asthma	Breast Cancer	Benign Prostate Hypertrophy
Carotid Artery Stenosis	Cerebrovascular Accident (Stroke)	Cholelithiasis (Gallstones)	Colon Cancer	Congestive Heart Failure
COPD	Coronary Artery Disease	Diabetes	Fracture	GERD
Headaches	Hyperlipidemia (High Cholesterol)	Hypertension (Blood Pressure)	Hypothyroidism	Iron Deficiency Anemia
Lung Cancer	Myocardial Infarction (Heart Attack)	Obesity	Osteoarthritis	Osteoporosis
Peptic Ulcer Disease	Prostate Cancer	Skin Cancer	Testicular Cancer	Recurrent Urinary Infections

OTHER: -

_____

SURGERIES: ***(Please circle any surgeries that you've had and the year or age that they occurred)***

Appendectomy	Arthroscopy	Biopsy	CABG (Heart Bypass)	Cataract Removal
Cholecystectomy (Gallbladder)	Circumcision	Coronary Artery Stent Placement	C-section	Dilation & Curettage (D&C)
Fracture Repair	Hernia Repair	Hysterectomy	Joint Replacement	Tubes in Ears
Prostatectomy	PTCA (Coronary Angioplasty)	Sinus Surgery	Tonsil/Adenoidectomy	Tubal Ligation
TURP	Vasectomy			

OTHER: _____

FAMILY HISTORY: ***(Please complete the following information on your relatives)***

	Age If Alive now	Age at time of death	Health Problems and/or Cause of Death
Father			
Mother			
Brothers (#_____)			
Sisters (#_____)			
Spouse			
Children (#_____)			
Grandparents			

NAME: _____ **DOB:** _____

SOCIAL/ PERSONAL HISTORY: ***(Please complete the following information about yourself.)***

Current Occupation:				
Education Completed:	□ Grade School	□ High School	□ College (degree):	□ Post Graduate (degree):
Marital Status:	□ Single	□ Married (Date):	□ Divorced (Date):	□ Widowed (Date):
Hobbies/ Recreation:				
Exercise:	Type:		Frequency/ Week:	
Do you identify with a specific religion?			□ YES	□ NO
If yes, which one?				
Do you attend church or another place of worship?			□ YES	□ NO
Current Tobacco Use:	Type:		Amount/Day:	
Former Smoker:	Amount/day:	Years:		Quit Date:
Exposed to Second-hand Smoke:		□ YES		□ NO
Alcohol Use:	Type:		Amount/Day:	
Recreational Drugs:	Type:		Amount/ Day:	
Caffeine Use: (soda, coffee, chocolate)	Type:		Amount/ Day:	

If there is anything else you'd like us to know about your health history, please tell us in the space below.

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