Covenant Medical Group
Health History Form

Patient Name: _____ Date of Birth: _____ Date of Service: _____

Please answer all questions, it is important for your health and our records.

Occupation/Employer: _____

In your own words, describe your problem and what brings you into our office today?

_____

_____

Infection Disease Screening:

Infectious Disease Risk Factors/Symptoms: (circle what applies)

Chills	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Headache	Yes	No
Muscle Pain	Yes	No
Vomiting	Yes	No
Weakness/Numbness	Yes	No

Have you or a family member traveled outside the US within the last 30 days? (circle what applies)

Yes, Patient
Yes, Family Member
Yes, Patient and Family Member
No
Unable to Obtain
Unable due to cognitive impairment/mental health status

If yes, Location of Travel: _____

Medical History (Please put "C" for Current medical problem or "P" for Past medical problems)

	Seasonal Allergies		Congestive Heart Failure		Kidney Disease
	Anemia		Coronary artery disease		Liver Disease
	Angina (Chest pain)		Crohn's Disease		Meningitis
	Anxiety		Colitis		Mental/Nervous Disorder
	Arthritis		Depression		Menopause
	Atrial Fibrillation		Diabetes		Migraine Headaches
	Autoimmune disease		Fibrocystic Breasts		Obesity
	Back pain/injury		Fractured Bones		Osteoporosis
	Bladder infection		Gallbladder Disease		Pancreatitis
	Bleeding Tendencies		GERD (Acid Reflux)		Peptic ulcer (stomach ulcer)
	Blood clot		Glaucoma		Phlebitis (vein inflammation)
	Blood transfusion		Heart Attack		Pneumonia
	Cancer_____		Hemorrhoids		Rheumatic Heart Disease
	Cancer_____		Hepatitis (A, B, or C)		Seizure
	Cancer_____		High Blood Pressure		Stroke
	Cataracts		High Cholesterol		Sexually transmitted infection
	Chronic Lung disease		Irritable bowel disease		Skin disorder
	Other_____		Other_____		Other_____

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Allergies: List any Allergies to medication, food or substances and describe the reactions (use back of page if necessary): No known allergies

Medication/other:	Allergic reaction:
_____	_____
_____	_____
_____	_____

Current Medications (List all medications, including supplements/vitamins taken)

Medication	Dose	Directions/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Use back of page if you take more medications than this.

Preferred Pharmacy (name and street address):_____

Online or mail in pharmacy if applicable_____

Social History (please circle or fill in answers as indicated)

Marital Status: Single Married Widowed Divorced How Many Children? _____

Tobacco Use:
Never
Current everyday tobacco user
Current some day tobacco user
Former tobacco user, quit more than 30 days ago
Refused tobacco status screen
Not screened for tobacco because of cognitive impairment

Type of Tobacco: Cigarettes Cigars Pipe Smokeless Cigarette Spit Tobacco
SNUS Pouches Electronic Cigarettes (Vape)

Use Per Day: _____ Number of Years: _____

Alcohol:
Never Used
Denies Use
Past User
Not used since pregnant
Used early in pregnancy
Unable to assess due to cognitive impairment
Current User

Type of Alcohol: Beer Wine Liquor Other: _____

Frequency: _____

Substance Use: Current Past Never

Type of Illegal Substances: _____ Frequency: _____

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Preventative History

Most recent dates for the following (year is ok if you don't know exact dates)

Last physical _____

Colonoscopy_____

Hepatitis C Screening _____

HIV Screening _____

Eye Exam: _____

Provider: _____

Where Performed: _____

Immunizations (please bring records of all if available)

Influenza (Flu) _____

Pneumovax 23_____

Pneumococcal 20 _____

Shingrix _____

Tetanus_____

COVID_____

Female:

Last pap smear date_____ Result: _____(normal, required follow up, required colposcopy)

Have you had a Hysterectomy?: yes no If yes what year?_____Were ovaries removed?____

Last Mammogram date _____ Result: _____(normal, required more imaging, required biopsy)

Last DEXA (Bone density): _____ Result: _____ (normal, required medication)

Birth Control Method: Condoms Pills IUD Shots partner vasectomy other_____

Male:

Last PSA date _____ Result: _____ (normal, required follow up, required biopsy)

Abdominal ultrasound date _____

Surgical History (list any surgeries you had, reason for surgery, year and where performed)

No Previous Surgeries

Surgery	Reason	State/hospital	Year

Current Providers: (list all specialists and previous primary care provider name and specialty):

_____

_____

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Family Medical History

Please indicate: Mother (M) Father (F) Siblings (S) Child (C) Grandfather (GF) Grandmother (GM)

Family Member	Medical Problem	Family Member	Medical Problem
	ADD/ADHD		High Blood Pressure
	Alcoholism		High Cholesterol
	Seasonal Allergies		Irritable Bowel Disease
	Alzheimer's or Dementia		Liver Disease
	Asthma		Mental Illness
	Blood Disease or Clotting Disorder		Migraine Headaches
	Coronary Artery Disease		Obesity
	Cancer, Type_____		Osteoarthritis
	Cancer, Type_____		Osteoporosis (low bone density)
	Cancer, Type_____		Peripheral Vascular Disease
	Depression		Renal (kidney) Disease
	Developmental Delay		Seizure Disorder
	Diabetes		Stroke
	Eczema		Other:_____
	Hearing deficiency		Other:_____
	Heart attack		Other:_____

Any unusual illnesses, early deaths or trends in your family?

_____

_____

Gender Identity and Sexual Orientation:

Do you think of your sexual orientation as: (circle what applies)

Lesbian, Gay, or Homosexual
Straight or Heterosexual
Bisexual
Something else, please describe (by selecting other)
Don't Know
Choose Not to Disclose
Other: _____

What is your current Gender Identity: (circle what applies)

Identifies as Male
Identifies as Female
Female to Male (FTM)/Transgender Male or Female
Male to Female (MTF)/Transgender Female or Male
Genderqueer, neither exclusively Male or Female
Choose Not to Disclose
Other: _____

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Social History

Lives with: (circle what applies)	Alone, Independent Alone, Needs Assistance Caregiver Child(ren) Family Father Friend Legal Guardian	Mother Parent(s) Siblings Significant Other Spouse Unable to Obtain Other: _____
Lives In: (circle what applies)	Apartment Facility Hotel/Motel Multilevel Home RV Camper/Motor Home Shelter Single Level Home	Split Level Home Street Tent Vehicle Unknown Unable to Obtain Other: _____
Living Situation: (circle what applies)	Assisted Living Extended Care Facility Group Home Home Homeless Hospice Law Enforcement Detention	Nursing Home Psychiatric Unit Rehabilitation Unit Skilled Nursing Facility Unable to Obtain Other: _____
Barriers at Home Affecting Care: (circle what applies)	No Barriers Identified Absence of Family Member Bug Infestation Food Insecurity Inadequate Drinking Water Supply Lack of Insurance Lack of Transportation Narrow Doorways No Air Conditioning No Electricity No Elevator Absence of Family Member due to Military Other: _____	No Heat No PCP No Phone No Running Water No Shower/Tub on 1st Lev Stairs: External Stairs: Internal Unable to Afford Meds Unemployed Upstairs Bedroom/Bathroom Unable to Obtain

Thank you for filling out our form.

Please remember to bring all former immunization records, lab work, and office notes that you have from your previous physician's offices to your first visit. Please also bring all your medications, in their bottles, with you to the visit even if you have filled out the medication paperwork. We want to get to know you as thoroughly and accurately as possible!