CARTHAGE FAMILY WELLNESS
HIGHPOINT HEALTH PARTNERS

Patient Health Information Form

Date:_____
Patient Name: _____ **DOB**:_____
Pharmacy (***name and number***)_____
(All new prescriptions and refills will be submitted electronically to your designated pharmacy)

What is the reason for your visit today? _____
Were you born between 1946 and 1964?_____**Have you been tested for Hepatitis C**?_____

Medical History: (Please circle all that apply)

Heart Disease	Stroke	High blood pressure	Diabetes
High Cholesterol	Asthma	COPD	Seizure
Thyroid problems	Liver disease	Hepatitis C	Hepatitis B
Acid Reflux	Irritable Bowel	Back pain	Fibromyalgia
Migraines	Anxiety	Depression	Crohn's
Ulcerative Colitis	Kidney disease	Cancer (list type)_____	

In general do you have any of the following symptoms? **(Circle all that apply)**

Trouble swallowing	Hoarseness	Constipation
Always Tired	Rectal Bleeding	Rectal Pain
Loss of appetite	Sore throat	Diarrhea
Weight loss/gain	Cough	Black/tarry stools
Shortness of breath	Hemorrhoids	Heartburn/acid reflux
Hepatitis	Loose stools	Abdominal pain
Nausea	Colon cancer	Abdominal bloating
Ulcers	Chest pain	Pelvic pain
Falls/stumbling	Vomiting/dry heaves	Recent imaging/labwork

Past Surgical History:

Surgery_____ Date:_____

Surgery_____ Date:_____

Surgery_____ Date:_____

Recent Hospitalizations/REASON:_____

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Family History: (Check all that apply) parents alive or deceased

	Colon cancer	Other cancer	Hypertension	Heart Disease	Liver Disease	Abnormal Cholesterol	diabetes	Thyroid Problems
Mother								
Father								
Brother								
Sister								
Son								
Daughter								
Grandparents								

Medications: (List all prescription and over the counter medications that you are currently taking)

Medication	Reason for taking	Dosage	Directions
Do you take aspirin? Yes/NO			

Allergies: (circle all that apply)
Sulfa Penicillin Statins (cholesterol medication) Codeine
Latex Other allergies: _____
Social History: (Check all that apply)
Tobacco Use: None____ 1pk/day____ 1+pk/day____ former smoker (year stopped)_____
Alcohol Use: None____ social_____ 1/day_____2-3/day____ 4+/day____ year stopped_____
Street Drugs: Never_____ In the past_____ Occasionally _____ Frequently_____

Signature:_____**Date**:_____