convenientMD PRIMARY CARE

Patient Information

Name:_____ Date of Birth:_____

Gender Identity: Female_____ Male_____ Other:_____ Decline to Answer_____

Who was your previous primary care provider?_____

Reason for today's visit:_____

Personal Medical History

Check all that apply.

Acid Reflux/GERD ☐	Asthma ☐	COPD/Emphysema ☐	Headaches ☐	HIV/AIDS ☐	STI/STD ☐
ADHD ☐	Bleeding Disorders ☐	Dementia ☐	Hearing Loss ☐	Kidney Disease ☐	Stroke ☐
Alcoholism ☐	Bowel Problems ☐	Depression ☐	Heart Disease ☐	Immune Disorders ☐	Thyroid Disease ☐
Anemia ☐	Cancer ☐	Diabetes ☐	Hepatitis ☐	Liver Disease ☐	Tuberculosis ☐
Anxiety ☐	Chronic Cough ☐	Eating Disorder ☐	High Blood Pressure ☐	Osteoporosis ☐	Other:
Arthritis ☐	Chronic Pain ☐	Glaucoma/Cataracts ☐	High Cholesterol ☐	Seizure Disorder ☐	Other:

Medications and Supplements

List everything you take regularly. Please include birth control, supplements, over-the-counter medications, and prescriptions.

Medication	Dose	Frequency	Date Started
Ex. Lisinopril	*Ex. 10 mg*	*Ex. Once daily*	*Ex. 2014*

Allergies

Allergen *(Ex. Penicillin, shellfish, ragweed, etc)*	Specific Reaction *(Ex. Rash, anaphylaxis, gastro issues, etc)*

Immunization History

Please include your best estimate of the month and year you received the following immunizations.

Pneumonia:_____ Unsure☐ Never☐

Shingles:_____ Unsure☐ Never☐

Influenza (Flu):_____ Unsure☐ Never☐

Tetanus:_____ Unsure☐ Never☐

COVID:_____ Unsure☐ Never☐

Please select one of the following options:

__☐__ I received all of the usual childhood immunizations

_☐_ I am unsure about my immunization history

__☐__ I refuse/have refused all immunizations.

I am interested in receiving/finding out more information about the _____ immunization.

Health Screening History

When was your....	Never, unsure or N/A	Date (mm/yyyy)	Results (if known)
Last Colonoscopy?			
Last Cholesterol Test?			
Last Prostate Blood Test?			
Last Bone Density Test?			
Last Mammogram?			
Last Pap Smear?			
Last A1C Test?			
Last Diabetes Screening?			
Last Dental Exam?			
Last Lung Cancer Screening?			

Have you ever had a Hepatitis C screening?

Have you ever had an HIV screening?

Hospitalization and Surgical History

Please list all operations, hospital stays, and major injuries or accidents. (Leave blank if none)

Date (mm/yyyy)	Description

Family Medical History

☐ I do not know my family history.

☐ I am adopted.

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/Stroke					
Diabetes					
Cancer (Type)					
Epilepsy					
Asthma					
Alive and Well					
Other:					

Alcohol, Tobacco, Drug Use

Tobacco Use? *If no, have you ever?*		Cigarettes☐Cigars☐Chew☐ Cigarettes☐Cigars☐Chew☐	Per Day: Per Day:
Do you drink alcohol?		Beer ☐ Wine ☐ Liquor ☐	Per Day:
Do you drink caffeine?		Coffee☐Tea☐Soda☐ Energy Drink☐	Per Day:
Any present illicit drug use?		Marijuana☐Cocaine☐Heroin☐Rx☐Other:	
Any past illicit drug use?		Marijuana☐Cocaine☐Heroin☐Rx☐Other:	
Do you exercise?		Type?	Per Week:
Do you wear your seatbelt?		Percent of Time:	
Do you have Advanced Directives in place?		Living Will ☐ Durable Power of Attorney ☐ Health Care Proxy ☐ Advanced Directives ☐	