

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 (1 st Pneumonia shot)			
Pneumovax(2 nd 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

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

Allergies

Please list all food and drug allergies:

Surgical History / Majo	r Diagnostic Procedure	es
Appendectomy	Gall Bladder	Hysterectomy
Back Surgery	Lung Biopsy	(was cancer involved)
Bariatric (Weight Reduction)	Lung Resection	Tonsillectomy
Breast	Heart Catheterization	Tubal Ligation
(was cancer involved)	Heart Bypass Surgery	Tumor Removal
C-Section	Prostate Surgery	Vasectomy
ther History/Details		

Hospitalizations/Emergency Room Visits

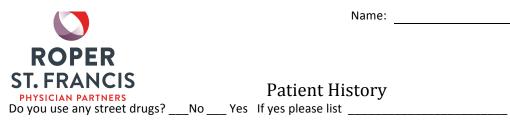
Reason	Date

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? ______



DOB: _____

Patient History

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							