WESTSIDE MEDICAL CLINIC **BASELINE HISTORY**

Name: _____ Date of birth: _____
Last **First** **Middle Initial**

What is the reason for your office visit today? ☐Upper Respiratory Infection ☐Hypertension ☐Diabetes ☐Chest Pain ☐Abdomen Pain ☐High Cholesterol ☐Migraines ☐Urinary Tract Infection ☐**Other: Describe below**

_____

MEDICATIONS (List all meds, strength & frequency, include non-prescriptions & herbs/supplements as well, if not taking any write **N/A**)

_____

_____

_____

PAST MEDICAL HISTORY & SURGERIES (List **ALL** diseases, conditions, hospitalizations & surgeries with dates)

_____

_____

_____

ALLERGIES (List all medications, foods or agents & the reaction) ☐No Drug Allergies

_____

FAMILY HISTORY: Please **CIRCLE** if family member Is **Alive / Deceased.**

Mother **(M)** **Alive / Deceased** Father **(F)** **Alive / Deceased** Paternal Grandmother **(PGM)** **Alive / Deceased**
Paternal Grandfather **(PGF)** **Alive / Deceased** Maternal Grandmother **(MGM)** **Alive / Deceased**
Maternal Grandfather **(MGF)** **Alive / Deceased** Brother **(B)** **Alive / Deceased** Sister **(S)** **Alive / Deceased**

Indicate if any immediate family members have the following conditions or diseases and who they are:

☐ Alzheimer's disease	☐Diabetes	☐Osteoporosis	☐ Other cancers _____
☐ Anemia	☐Hypertension	☐ Prostate Cancer	☐ Others _____
☐ Bleeding Disorder	☐Colon Cancer	☐Thyroid Disease	_____
☐Breast Cancer	☐Melanoma	☐Heart attack / coronary artery disease	

SOCIAL HISTORY:

Tobacco: ☐ **NON-SMOKER** **Second hand smoke exposure** ☐**Yes** ☐**No** ☐Quit Date: _____
☐Currently use How much? _____pack/day Duration: _____ mth /years
☐Past use How much? _____pack/day Duration: _____ mth /years

Alcohol: ☐ **Don't Drink** ☐ Quit Date: _____
☐ Currently use How much? _____day/wk Duration: _____ mth /years
☐ Past use How much? _____day/wk Duration: _____ mth /years

Exercise: ☐Yes ☐No Type: _____ How long? _____Hrs. Frequency _____days a week
Diet: _____Occupation: _____
Any history of sexually transmitted disease? ☐YES ☐NO When? _____ Was it treated? ☐YES ☐NO
Any recreational drug use? ☐YES ☐NO If yes indicate: _____

IMMUNIZATION HISTORY: When was your most recent?

Tetanus Shot (Td) _____ Hepatitis B: _____ Pneumococcal Vaccine: _____ Flu Shot _____

PAST PREVENTIVE CARE: When was your most recent?

Annual Physical Exam: _____ Well Woman Exam: _____ Eye Exam: _____ EKG: _____

Mammogram: _____**Normal / Abnormal** Bone Density Test: _____ **Normal / Abnormal**

Colonoscopy / Sigmoidoscopy: _____**Normal / Abnormal** PSA/Prostate Screen: _____ **Normal / Abnormal**

Patient Signature: _____ Date: _____