ConneXtCare™
A Community of Care

Health History

Patient Name:_____Date of Birth:_____

Sex: ☐ Male ☐ Female Second-Hand Smoke Exposure: ☐ Currently ☐ In the Past ☐ Never

Previous/current Primary Care Provider:_____ Date of last physical exam: _____

Medical/Social History						
	Patient		Patient's Mother		Patient's Father	
High Blood Pressure	Yes	No	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No
High Cholesterol	Yes	No	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	Yes	No
COPD	Yes	No	Yes	No	Yes	No
Colon Cancer	Yes	No	Yes	No	Yes	No
Cervical Cancer	Yes	No	Yes	No	Yes	No
Breast Cancer	Yes	No	Yes	No	Yes	No
Anxiety	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Nicotine Dependence	Yes	No	Yes	No	Yes	No
Alcohol Dependence	Yes	No	Yes	No	Yes	No
Other drug dependence	Yes	No	Yes	No	Yes	No
Physical Disability	Yes	No	Yes	No	Yes	No
Learning Disability	Yes	No	Yes	No	Yes	No

Please list any other medical issues you would like us to be aware of:_____

_____

_____

Current Medications	Dose and Frequency	Prescriber
If you need more space to record medications or any other info, please ask the front desk for additional paper		
Allergies	**Reaction**	

Name: _____ DOB: _____

Surgical History		
Where When	**What**	

Recent Hospitalizations/ER Visits (past 3 months)		
Where	**When**	**Why**

Please list any specialists that you are currently seeing, or have seen in the past two years		
Name	**Specialty**	**Last Visit**

Smoking History:

Never Smoked Y N
Current smoker Y N
Former smoker Y N
Chew/Dip/Snuff Y N
Vape/e-cigarettes Y N
Age when started____ years
Age when quit____years
Average number of packs per day_____

Immunizations (shots)	
Type	Date
Flu	
Td/tdap	
Prevnar	
Pneumonia	
Shingles (zostvax/shingrix)	

Date of most recent:

Dental Exam:_____ Eye Exam:_____
Labs:_____Bone Density:_____
Pap Smear:_____Mammogram: _____
Colonoscopy:_____
Other (EKG, Ultrasound, CAT Scan, MRI):_____

Are you sexually active? ☐ Yes ☐ No Are you interested in HIV testing? ☐Yes ☐ No

Do you use alcohol or drugs of any kind? ☐Yes ☐ No Do you consume Caffeine? ☐Yes ☐No

Signature of Patient/Guardian: _____ Date:_____

Pediatric Patients Only:

Patient was born at how many weeks?_____ Birth Weight:_____Length: _____

Place of Birth: _____ ☐ Cesarean ☐ Vaginal

Are the patient's immunizations up to date? ☐ Yes ☐ No

Do you give permission for us to access the patient's state immunization record (NYSIIS)? ☐ Yes ☐ No