



Lake Country Medical Concierge

(706) 817-9464 - 119 Harmony Crossing STE 3, Eatonton, GA 31024

Please complete all 3 pages.

PATIENT NAME: _____

EMAIL: _____

PRESENT HEALTH CONCERNS:

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

Congenital Heart Disease: specify type: _____

Coagulation (bleeding/clotting) disorder

Heartburn

Stroke

Thyroid problem: specify type: _____

Asthma

High blood pressure

Alcoholism

Other problems: _____

Ulcer (stomach/intestine)

Cancer

Heart attack

Emphysema

History of blood transfusion

Depression

Diabetes

High cholesterol

MEDICATIONS: Prescription and non-prescription medications, vitamins, birth control pills, herbs:

Medication, Supplement, Vitamin	Dose	Times/Day	Medication, Supplement, Vitamin	Dose	Times /Day

ALLERGIES to Medications, Foods or Other Agents:

Medication	Reaction or Side Effect

SURGICAL HISTORY (please list all prior surgeries and dates):

Operation	Date	Operation	Date

FAMILY HISTORY:

Medical Condition	Mo m	Dad	Bro.	Sis.	chil d	oth e r	Medical Condition	Mo m	Dad	Bro.	Sis.	chil d	oth e r	oth e r
Alcoholism							Other cancer							
Anemia							Glaucoma							
Anesthesia issue							Seasonal allergies							
Rheumatoid Arthritis							Hearing problems							
Asthma							Heart attack							
Birth defects							High blood pressure							
Bleeding problem							High cholesterol							
Breast Cancer							Kidney disease							
Colon cancer							Lupus							
Skin cancer							Migraine headaches							
Melanoma							Osteoarthritis							
Ovarian cancer							Osteoporosis							
Prostate cancer							Stroke							
Depression							Thyroid disorders							
Type I diabetes							Eczema							

Type II diabetes							Epilepsy (seizures)							
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SOCIAL HISTORY:

Occupation: _____ Marital status: _____ Number of children: _____

Who lives at home with you? _____

Do you use seatbelts consistently? _____ Do you use a bike helmet regularly? _____

Is violence at home a concern for you? _____ Do you feel safe in your current relationship? _____

Do you have a gun in your home? _____

How frequently do you use sunscreen? _____

Are you a cigarette smoker? _____ If so, are you interested in quitting? _____

Have you ever been a smoker? _____ If so, how many packs/day? _____ # of years _____ Year quit: _____

How many drinks of alcohol per week? _____ Is your alcohol use a concern for you or others? _____ Do you use marijuana? _____ If so, how frequently? _____

Do you use any other recreational drugs? _____ Have you ever used IV drugs? _____ Do you exercise regularly? _____ If so, what exercise and how often? _____

During the past month, have you often:

1. Felt little interest or pleasure in doing things? ___yes ___no
2. Felt down, depressed or hopeless? ___yes ___no

SEXUAL HISTORY:

Are you sexually active? ___yes ___no ___not currently Sexual partner(s) is/are: ___ male ___ female ___ both Birth control method: _____ or ___none needed

If sexually active, do you practice safe sex? ___yes ___no. Have you ever had a sexually transmitted disease? ___yes ___no

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies: _____ # deliveries: _____ # abortions: _____ # miscarriages: _____

Age at first period: _____ Date of last pap smear: _____ Any abnormal pap smears in the past? _____ Last period? _____

SCREENING:

Date of most recent:

Colonoscopy: _____ Normal? ___yes ___no

Mammogram: _____ Normal? ___yes ___no

Eye Exam: _____ Normal? ___yes ___no

Bone density test: _____ Normal? ___yes ___no

Which is your preferred pharmacy? _____ City/Town: _____

Who is your Health Care Proxy? _____ Phone: _____ Relation: _____

