**Pinner Clinic, PA**

*A Rich History of Medical Tradition Since 1915*

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**Patient Health Assessment**

**Patient Name (PLEASE PRINT):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DRUG ALLERGIES:** Please list ALL medications you are allergic to.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS MEDICAL ILLNESSES:** Please check any illnesses you have had in the past.

|  |  |  |
| --- | --- | --- |
| * Anemia / Low Blood | * Epilepsy / Seizures | * Rheumatic Fever |
| * Anxiety | * Gallstones | * Skin Disease, Type: \_\_\_\_\_\_\_ |
| * Asthma | * Glaucoma | * Stroke |
| * Bleeding from Bowels | * Gout | * Thyroid Problems |
| * Bleeding Problems, Type: \_\_\_\_\_\_\_\_\_\_\_ | * Heart Attack | * Tuberculosis |
| * Blood Clot in Leg | * Heart Murmur | * Ulcers in Bowels / Stomach |
| * Blood Clot in Lung | * Hepatitis/Liver Disease | * Varicose Veins or Spider Veins |
| * Blood Transfusion | * High Blood Pressure | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * High Cholesterol | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Communicable Disease, Type: \_\_\_\_\_\_\_ | * HIV | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Congestive Heart Failure | * Irregular Heart Beat | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Depression | * Kidney Disease, Type: \_\_\_\_\_\_\_\_\_ | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Diabetes / High Blood Sugar | * Kidney Stones | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Emphysema / Chronic Bronchitis | * Prostate Problems | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SURGICAL HISTORY:** Please provide dates for any surgeries you have had.

|  |  |
| --- | --- |
| **SURGERY** | **DATE** |
| Appendectomy |  |
| Joint Scope Surgery |  |
| Biopsy |  |
| Open Heart Surgery |  |
| Neck Artery Surgery |  |
| Cataract Surgery □ R □ L |  |
| Gallbladder |  |
| Broken Bone Repair |  |
| Joint Replacement |  |

|  |  |
| --- | --- |
| **SURGERY** | **DATE** |
| Back Disc Surgery |  |
| Abdominal Surgery |  |
| Tonsils Removed |  |
| Prostate Surgery |  |
| Vasectomy |  |
| Tubal Ligation |  |
| Hysterectomy (Complete? □ Y □ N) |  |
| Mastectomy □ R □ L |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**CONTINUE 🡪**

**Patient Health Assessment, continued**

**CURRENT MEDICATIONS:** Please list ALL medications you are currently taking. Include dosage and how often you take each medication.

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| --- | --- | --- |
| **MEDICATION (including over-the-counter)** | **DOSAGE** | **HOW OFTEN DO YOU TAKE?** |
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**IMMEDIATE FAMILY HISTORY:** Check beside any disease that has affected your mom, dad, brothers, and/or sisters.

|  |  |
| --- | --- |
|  | Heart Attack |
|  | High Blood Pressure |
|  | High Cholesterol |
|  | Asthma |
|  | Tuberculosis |
|  | Liver Disease |
|  | Kidney Disease |
|  | Osteoporosis |
|  | Stroke |
|  | Epilepsy / Seizures |
|  | Bleeding Problems |
|  | Sickle Cell Anemia |
|  | Diabetes / High Blood Sugar |
|  | Thyroid Problems |
|  | Cancer, Type: |
|  | Alcohol Abuse |
|  | Anxiety or Depression |
|  | Glaucoma |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SPECIALISTS YOU ARE CURRENTLY SEEING:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Specialty** | **Specialist’s Name** | **Location/Address** | **Phone Number** |
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| --- | --- | --- |
|  | | |
| How often do you exercise?  Never  Occasionally  Several Times Per Week  Every Day | | |
| Have you ever smoked?  Yes  No | Number of Years: \_\_\_\_\_ | How much do you/did you smoke every day? \_\_\_\_ # Cigarettes \_\_\_\_ # Packs |
| Do you use any of the following tobacco (other than cigarettes)?  Pipe  Snuff  Cigars  Chewing Tobacco  Dip  Electronic Cigarettes  Vapor | | |

**Patient Health Assessment, continued**

**Patient Name :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Females ONLY:**

**Are you pregnant or planning to be pregnant soon?**  Yes  No

**Currently breast feeding?**  Yes  No

**Number of:** Pregnancies? \_\_\_\_ Miscarriages? \_\_\_\_ Deliveries? \_\_\_\_\_

**Have you ever had postpartum depression?**  Yes  No  Not Sure

**Current form of birth control:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of most recent: Pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram**? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any abnormal results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of most recent menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**