**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.

|  |  |  |
| --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**