Green Hill Family Health Center
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Getting to Know You

This information will help us get to know you. What you write on this form is confidential and protected by law.

Legal Name: _____

Birthday: _____ (Month/Day/Year)

Legal Sex: □ Male □ Female
If your preferred name or pronouns are different than your legal documentation, please let us know.

What doctor or provider did you see before?

Name:
Location:

Name:
Location:

Name:
Location:

What Pharmacy do you use?

First choice:	Second Choice:
Name:	Name:
Address:	Address:
Phone:	Phone:

Is there someone who usually helps you with your medical information, or your medicines?

Name:
Relationship:
(Ask us about signing a HIPAA form so we can share information with the people you choose).

What hobbies or interests do you have:

Patient Name:___________________________________DOB:______________________________

Getting to Know You continued

We want to know about any prescription and over-the-counter medicines you take. Bring your pill bottles and packages with you each time you visit, and we will review them with you.

Name of Medication	Strength	How many do you take?	How often do you take them?
Example: Tylenol	500 mg	1 pill	3 times each day

Patient Name:_____DOB: _____

Getting to Know You continued

Tell us more about you.....

Are you allergic to anything?

□ I'm not allergic to anything. □ I'm allergic to some medicines.

□ I'm allergic to latex. □ I have seasonal allergies (environmental allergies)

What are you allergic to?	What happens? How do you react?

Are you: □ Single □ In a relationship □ Married □ Divorced □ Widowed

What is your significant other/spouse/partner's name?_____

Do you have children?

Child's name		Age		Gender

Do you live with anyone? □ Yes □ No

Do you work? □ Yes □ No □ Disabled □ Retired
If yes, where do you work?_____

Do you have a..... □ Living Will □ Durable □ Power of Attorney □ Health Care Proxy
□ Advanced Directive □ Other

Do you have a copy?_____

Patient Name:_____DOB: _____

Getting to Know You continued

Your Health History
Please check any problems you have now and in the past. Mark the year it happened if you know.

X	Problem	Year	X	Problem	Year	X	Problem	Year
	Abnormal Pap Smear			Eating Disorder			Osteoporosis	
	Acne			Eczema			Osteopenia	
	ADD/ADHA			Emphysema			Positive TB skin Test	
	Alcohol Abuse Anemia			Gallstones Glaucoma			Prostate Problems Psoriasis	
	Anxiety Disorder			Gout			Reflux (Heartburn)	
	Asthma			Heart Attack			Rheumatoid Arthritis	
	Bipolar Disorder			Heart Condition*			Rosacea	
	Bladder Infections or UTI			Hepatitis (A,B,C)			Seasonal Allergies	
	Blood Clot			High Blood Pressure			Seizures	
	Blood Transfusion			High Cholesterol			Sinus Infections	
	Cancer*			Intestinal/ Bowel Disease			STD*	
	Chronic Bronchitis			Kidney Disease			Stomach Ulcers	
	Colon Polyps			Kidney Infections			Stroke or TIA	
	Depression			Kidney Stones			Tuberculosis	
	Diabetes			Lupus			Thyroid Disease	
	Diverticulitis Drug Abuse			Migraines Osteoarthritis			Ulcerative Colitis Warts	
	Other			Other			Other	

***What type(s) of Cancer, heart disease or STD's?**_____

_____

_____

Patient Name:_____ DOB: _____

Getting to Know You continued

Tell us about any surgeries you've had……(Please mark all that apply)

X	Type of Surgery	Year	X	Type of Surgery	Year
	Appendectomy (Appendix)			Hernia Repair	
	Back or Neck Surgery			Knee or Hip Replacement	
	Cataract Surgery			Mastectomy or Lumpectomy	
	C-Section			Polyp Removal (Colon)	
	Gallbladder Removal			Tonsillectomy/Adenoidectomy	
	Heart Surgery*			Tubal Ligation or Vasectomy	
	Hemorrhoids			Plastic Surgery*	
	Other:			Other:	

***What type(s) of heart or plastic surgery have you had done?**_____

_____

Are there any other problems or surgeries you'd like us to know about?_____

_____

Do you follow a specific diet when you eat?_____

(some examples include vegan, vegetarian, calorie restriction, diabetic, low salt, low fat)

Do you exercise? □ Yes □ No

If yes, what do you do?_____ How often?_____

Do you drink Caffeine? □ Yes □ No How many cups per day?_____

Do you drink Alcohol? □ Yes □ No How many glasses per day?_____

Do you use Drugs? □ Yes □ No What types, and how often?_____

Do drugs cause a problem in your life? □ Yes □ No

Have you tried to stop? □ Yes □ No

Patient Name:_____DOB: _____

Getting to Know You continued

Let's talk about how you stay healthy……
Have you ever smoked or used smokeless Tobacco? □ No □ Yes
□ Yes, but I stopped in_____

If you still smoke:

How many years smoking/ using smokeless tobacco?_____

How many packs/cans per day?_____

Have you ever tried to quit?_____

Would you like help with quitting?_____

Tell us about your immunizations and test. Tell us the date if you remember.

Tetanus Shot	Date:_____			
Shingles Vaccine	Date:_____			
Pneumonia 13 or Prevnar	Date:_____			
Flu Shot	Date:_____			
Eye Examination	Date:_____	□ Normal	□ Abnormal	□ Unknown
Hearing Exam	Date:_____	□ Normal	□ Abnormal	□ Unknown
Colonoscopy or stool Test	Date:_____	□ Normal	□ Abnormal	□ Unknown
Dexa Scan (bones)	Date:_____	□ Normal	□ Abnormal	□ Unknown
Last Pneumonia Vaccine	Date:_____			
Cholesterol Check	Date:_____	□ Normal	□ Abnormal	□ Unknown
Blood Sugar Check	Date:_____	□ Normal	□ Abnormal	□ Unknown
Pap Smear	Date:_____	□ Normal	□ Abnormal	□ Unknown
Mammogram	Date:_____	□ Normal	□ Abnormal	□ Unknown

Let us know what we can help you with while you are here.
What concerns do you have?_____

Patient Name:_____ DOB: _____

Getting to Know You continued

Tell us about your family.

The health of your family can tell us about your healthcare needs. It also helps us to determine when you need certain screening tests. Please use the table below to tell us what health conditions your family has now or had in the past. In the boxes, write the age your family member was when they had the condition.

Illness/Condition:	Mother	Father	Sister	Brother	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Sons	Daughters	Other	None
Cancer*												
Heart Disease												
Diabetes												
Stroke/TIA												
High Blood Pressure												
High Cholesterol												
Liver Disease												
Anxiety/Depression												
Alcohol/Drug Abuse												
Tuberculosis												
Psychiatric Illness												
Genetic Disorder												
Kidney Disease												
Eye Disease												
Other-Disorder*												

*Is there any other family information we should know?_____

_____

_____

Your Name: (Printed)_____ Date:_____

Your Signature:_____ Date:_____