AdventHealth Ottawa

PATIENT HISTORY FORM

1428 S. Main Street, Suite 4, Ottawa, KS
833-RMH-CARE or 785-229-8882

Patient Name: _____ **DOB:** _____

Gender: ❑ Male ❑ Female Local Pharmacy of Choice: _____

Mail in Pharmacy Name: _____
(Please provide copy of Rx Card at Registration)

PAST MEDICAL HISTORY (please answer all questions to the best of your ability):

Do you have now or have you had:	Yes	No	Do you have now or have you had:	Yes	No
Tuberculosis (TB)			Thyroid Problems		
Cancer			Stomach Problems/GERD		
High Blood Pressure			Intestinal Disease		
Heart Attack			Liver Disease		
Kidney Disease			Seizures		
Lung Disease – COPD/Asthma			Urinary Issues		
Diabetes – Type 1 or 2			Anxiety		
Depression			Bipolar		
Other:					

Please explain all YES answers:

_____

_____

_____

FAMILY HISTORY (please add family members as needed):

Family Member	Living/ Deceased	Age (now or age deceased)	Medical Problem/Cause of Death
Mother	❑ Living ❑ Deceased		
Father	❑ Living ❑ Deceased		
Siblings	❑ Living ❑ Deceased		

Any Family With:	Who?	Type	Age
Cancer *(prostate, breast, lung)*			
Diabetes			
Heart Attack			
Stroke			

SOCIAL HISTORY:

Do you now or have you ever used:

1. Tobacco (cigarettes, chewing tobacco, pipes, e-cigarettes, etc.)? ❑ Yes ❑ No Date Quit _____
   If yes, how long? _____
2. Alcohol (beer, liquor, wine, etc.) ❑ Yes ❑ No ❑ Quit
   If yes, how long? _____ No. drinks per day _____
3. Caffeinated beverages (soda, coffee, tea, energy drinks, etc.) ❑ Yes ❑ No ❑ Quit
   If yes, how long? _____ No. drinks per day _____
4. Illicit drugs (injected, inhaled, other) ❑ Yes ❑ No ❑ Quit
   If yes, how long? _____ What drug _____

Do you have any medication, food, or environmental allergies?

_____

_____

_____

Please list any prior surgeries: _____

Last Colonoscopy (year): _____ Results: _____ Surgeon/place: _____

Please list current medications (bring medication bottles with you to your appointment):

_____

_____

_____

Do you have any health concerns that you would like to discuss with your provider today?

_____

_____

_____

Do you have:	Yes	No	If yes, POA Name/Number:
Power of Attorney			
Advanced Directive			
Living Will			
Do Not Resuscitate			