

## PATIENT HISTORY FORM

Please complete all sections of this form. Incomplete information may delay your care. To help us provide the best possible treatment, please list **McCrimmon Primary Care Plus** at other healthcare facilities and notify us about any medical services you receive outside of our practice.

### Personal Information

Legal Name (Last, Middle, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child/Adolescent (0–17 years)       Adult (18+ years)

### Medication Information

Please list all medications, supplements, or vitamins you currently take, including dosage and how often:

I am not currently taking any medications

### Allergies

Please list all allergies to medications, foods, or environmental and describe the reaction:

No known allergies

### Past Medical History

**Adults:** Please indicate if you have had the following:

**Children:** List serious illnesses, injuries, or conditions (with dates):

- |                                    |   |  |   |                                     |
|------------------------------------|---|--|---|-------------------------------------|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Stroke     |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Asthma                           | <input type="checkbox"/> COPD / Emphysema                | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Seizures                         | <input type="checkbox"/> Congestive Heart Failure        | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Arthritis  |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Heartburn / Reflux               | <input type="checkbox"/> Sleep Apnea                     | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> ADHD       |
| <input type="checkbox"/> ADD       | <input type="checkbox"/> Abnormal Mammogram / Breast Exam | <input type="checkbox"/> Other medical conditions: _____ |   |                                     |

### Surgeries & Hospitalizations

Surgeries or major procedures (with dates): \_\_\_\_\_  None

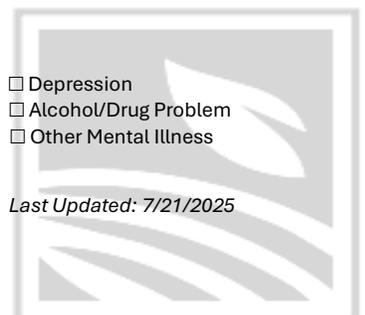
Hospitalizations (admissions, with dates in the past 5 years): \_\_\_\_\_  None

### Family Medical History

Do any siblings, parents, or grandparents have any of the following?

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Tuberculosis Contact | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Alcohol/Drug Problem |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity              | <input type="checkbox"/> Eczema/Dry Skin | <input type="checkbox"/> Other Mental Illness |

Last Updated: 7/21/2025



# McCRIMMON PRIMARY CARE *plus*

If you selected any, please list the condition and the family member (e.g., paternal grandfather, sibling):

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### Primary Care Information

Do you consider McCrimmon Primary Care Plus your primary care Provider?  Yes  No

If no, please list current PCP name: \_\_\_\_\_

Do you or your child regularly see any other specialists or providers?  Yes  No

If yes, list name and reason/specialty: \_\_\_\_\_

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### Social / Environmental / Safety History (Child/Adolescent Only)

(Please check Yes or No for each item)

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Always uses a car seat/seatbelt in vehicles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wears helmet when biking/skating/etc.       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Smoker's present in the household           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weapons present in the home                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, weapons are secured and locked      |
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### Patient's Parent or Legal Guardian Certifying Information Provided on this Form

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date



Last Updated: 7/21/2025