GILBERT MEDICAL GROUP PATIENT HISTORY FORM (PORTAL SUPPLEMENT)

LAST NAME FIRST NAME DATE

Who referred you to our office?_____

USE THIS SPACE TO LIST / DOCUMENT ANY ADDITIONAL MEDICAL CONDITIONS / SYMPTOMS NOT LISTED ON THE ONLINE / IPAD QUESTIONAIRE: _____

LIST ALL MEDICATIONS CURRENTLY TAKING (include dosage and times taken during the day or if taking as needed):

(Drug Name)	(Dosage)	(Times Taken per day)	(Diagnosis – taken for what illness)

DIAGNOSTIC PROCEDURES/ HEALTH SCREENINGS (List dates for the following below if applicable):

ECHOCARDIOGRAM: _____

EKG: _____

COLONOSCOPY/ FLEXIBLE SIGMOIDOSCOPY: (Date and results) _____

EYE EXAM: _____ DENTAL VISIT: _____

RECTAL EXAM: _____ PROSTATE: _____

BONE DENSITY: _____ MRI: _____

CT SCAN: _____ ULTRASOUNDS: _____

BLOOD WORK: _____ XRAY: _____

ADDITIONAL INFORMATION:

Do you feel safe in your relationship? _____

Is violence at home a concern for you? _____

If sexually active, do you practice safe sex / using protection (list type of protection) _____

Are your sexual partners male, female, or both? _____

Who lives at home with you? _____

Have you felt sad or down in the last two weeks? _____

Have you lost interest in activities you usually enjoy? _____

How would you rate your overall level of health; 0 being "the worst possible" and 100 is "Great, no problems whatsoever:"

Physical Health: _____ Mental Health: _____

Recent Travel (List locations): _____

I certify that the above information is true and accurate to the best of my ability:

Patient/Guardian Signature: _____ Date: _____