
Buford Care Patient History -

Please answer the questions below. PLEASE BE AS SPECIFIC AS POSSIBLE AND INCLUDE ALL CONDITIONS. IT IS CRUCIAL THAT YOU INCLUDE ALL HEALTH INFORMATION AS IT WILL ASSIST WITH TREATMENT

Personal Medical History: Conditions - current or treated in the past. (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn / Gastric Reflux |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer (add comments below) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> COPD / Breathing Problems | <input type="checkbox"/> Leg / Foot Ulcers |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Dementia / Memory Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stomach or Duodenal Ulcers |
| <input type="checkbox"/> NONE | <input type="checkbox"/> Urinary Tract Infections |

Any other medical issues not mentioned above:

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*****FORM CONTINUES, PLEASE SCROLL DOWN*****

Surgical History (Check all that apply)

- Appendectomy Date of Surgery:
- Cardiac Bypass Surgery Date of Surgery:
- Cholecystectomy Date of Surgery:
- Hernia Repair Date of Surgery:
- Tonsillectomy Date of Surgery:
- Skin Lesions Removed Date of Surgery:
- None

Any other surgeries not mentioned above

Injuries and bone fractures

Blood Transfusion

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Allergies (PLEASE STATE ALLERGEN AND REACTION)

| | Allergen | Reaction |
|--------------------------|---------------------------|-----------------|
| <input type="checkbox"/> | Indoor Allergies | |
| <input type="checkbox"/> | Outdoor Allergies | |
| <input type="checkbox"/> | Food Allergies | |
| <input type="checkbox"/> | Medications | |
| <input type="checkbox"/> | Immunizations (Reactions) | |
| <input type="checkbox"/> | NO KNOWN ALLERGIES | |

List Current Medications, Please indicate the name, dosing and frequency

Pharmacy Name - Preferred:

Pharmacy Street Address:

Pharmacy Name - Mail Order:

Prefer 30 Day Refill:

Prefer 90 Day Refill:

Immunizations:

Select all the immunizations received. If possible, please list the year you received a vaccination

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- Hepatitis A
- Hepatitis B
- Diphtheria
- Pertussis
- Tetanus
- Haemophilus Influenza Type B
- Polio
- Pneumococcal
- Measles
- Mumps
- Rubella
- Varicella (Chicken Pox)
- Influenza
- Rotovirus
- Human Papilloma Virus (HPV)
- COVID-19

Other:

Smoking Status

- Never Smoker
- Former Smoker
- Current Every Day Smoker
- Current Some Day Smoker
- Heavy Tobacco Smoker
- Light Tobacco Smoker

Has Smoked For:

How Many packs

Quit Date, If Applicable:

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If currently a smoker, are you interested to quit?

Yes No

Alcohol Use

Do you drink alcohol? Yes No

Type:

Drinks / Week:

History of Drug Use:

Yes / No

Are You Employed?

Occupation:

If Retired Or Disabled, What Kind Of Job Did You Perform?

Social History:

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Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Domestic Partner

Lives With (select all that apply):

- Father
- Mother
- Siblings
- Foster Family
- Grandparents
- Step Parent / Family

Other:

Sexual Activity

- Never:
- Current:
- Past:

Partners

- Spouse:
- Significant Other:
- Male:
- Female:

Please list the year that you have received the following screenings:

Bone Density Screening:

Colonoscopy:

Digital Rectal Exam:

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Cancer (add comments below)

Comments: