ProHealth™ PHYSICIANS
Part of OptumCare®

ProHealthMD.com

Current patient health history form (page 1 of 2)

First name: _____ Last name: _____

Today's date: _____ Date of birth: _____

List any concerns you want to talk about during your visit: _____

_____

Health history: Please list any changes since last preventive care visit. ☐ **No changes**
Health conditions or surgeries/hospitalizations (new since last visit)? If yes, list below.

Changes to social history:	
Do you smoke cigarettes?	☐ Never ☐ Yes _____ # packs/day ☐ Quit Date quit _____ Years smoked _____
Do you vape (e-cigarettes)?	☐ No ☐ Yes
Do you drink alcohol?	☐ Never ☐ Yes _____ # drinks per week
Do you use recreational drugs?	☐ Never ☐ Rarely _____# times per month ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Other _____
Are you employed?	☐ No ☐ Retired ☐ Yes Type of work_____
Do you exercise?	☐ No ☐ Yes Type _____ How often _____ How long per activity _____
What is your marital status?	☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Single ☐ Widow/er
Are you sexually active?	☐ No ☐ Yes # of new sexual partners (since last physical) _____ Sexual partners: ☐ Men ☐ Women ☐ Both Contraception: ☐ No ☐ Yes If yes, method _____
What was the date of your last period?	☐ N/A or First day of last menstrual cycle _____ # of days between menstrual cycles _____
Do you have children?	☐ No ☐ Yes # of children _____ ages of children _____

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Current patient health history form (page 2 of 2)

First name: _____ Last name: _____ Date of birth: _____

Changes to family history: ☐ **No changes**	
Relation	**Health conditions**
Mother	
Father	
Children	
Brother/Sister	
Family history of cancer (new cases since last visit)? If yes, list relative and type of cancer.	

New specialists seen: ☐ **No changes**		
Name	**Specialty**	**Town / City**

Preventive care:			
Recent shots from a **non-ProHealth** doctor or pharmacist	☐ Flu	Date:	Place:
	☐ Shingles	Date:	Place:
	☐ Pneumonia	Date:	Place:
	☐ Tetanus	Date:	Place:
	☐ Other	Date:	Place:
Recent tests or procedures	☐ Colonoscopy	Date:	Place:
	☐ Cologuard/Stool card	Date:	Place:
	☐ Mammogram	Date:	Place:
	☐ PAP	Date:	Place:
Other:			

Pharmacies:		
	Name	**Location**
Local		
Mail order		