Faith Home Care Practitioners, PLLC
34 NE Boistfort St. Ste. 123, Chehalis, WA 98532
360-996-4443 (Office) ● 855-619-1638 (Fax) ● www.faithhcp.com

Full Name:____ Birth Date:____________________

ALLERGIES o NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

PREFERRED PHARMACY: ____________________

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Asthma			
Cancer *(type:_______________________________)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____________________________)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			

FAMILY MEDICAL HISTORY ◯ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer *(type:)*	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:	Other:_____	Other:
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		

Patient Name: ____ DOB: ______________________

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SOCIAL HISTORY

Occupation *(or prior occupation)*:	o Retired o Unemployed o LOA o Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:______________________	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day______# of Years ________	***Past:*** Quit Date:__________________Packs/day_______# of Years ________		
Other Tobacco *(check one)*: o Pipe o Cigar o Snuff o Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:__________________________		
Other:__________________________		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Have you been exposed to COVID-19 in the past 14 days? Y N	If yes, where?

Patient Name: ____ DOB: ______________________________