Lifesprk SHINE ON™ Whole Person Senior Care | Health Primary Care

Member Health History Information

Please complete prior to your appointment. Thank you!

Last: ________________________ First: ______________________ MI:__ DOB: __/__/____

Preferred name: _______________________

Medical History

Allergies (list reaction, if known):

____

____

Height: ________________________ Weight: ________________________

Please check to indicate if you have ever had the following conditions:

❑ Arthritis	❑ Diabetes	❑ Infections: Type
❑ Asthma/COPD	❑ Eye problems: Type	❑ Kidney disease
❑ Cancer: Type	❑ Falls	❑ Neuromuscular disease
❑ Congestive Heart Failure	❑ Heart Arrhythmia	❑ Osteoporosis
❑ Constipation	❑ Heart Attack	❑ Parkinson's Disease
❑ Coronary Artery Disease	❑ High Blood Pressure	❑ Seizures
❑ Dementia/Alzheimer's	❑ High Cholesterol	❑ Stroke
❑ Depression	❑ Incontinence	❑ Thyroid Disease
❑ Other:		

Surgical and Hospitalization History

Type of surgery, hospital stay, or Emergency Room visits | Approximate date/year

____ ____________________

____ ____________________

____ ____________________

____ ____________________

____ ____________________

Specialty Care

Are you receiving care from other doctors, chiropractors or other specialty health care professionals? If yes, we would like to know so that we can coordinate your care:

Provider's name | Last date of visit | Condition they are treating you for

____

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Preventive Health Services

Immunizations	**Date/Year**	**Immunizations**	**Date/Year**
Influenza	___________	Tetanus	___________
Pneumonia	___________	Shingles	___________

Screenings	**Date/Year**	**Screenings**	**Date/Year**
Blood sugar	___________	Colonoscopy	___________
Blood in stool	___________	Mammogram	___________
Cholesterol	___________	Osteoporosis/Dexa scan	___________
Annual Wellness Visit	___________		

Family History

Condition	None	Mother	Father	Sister	Brother
Asthma					
Cancer					
Dementia/Alzheimer's					
Depression/Anxiety					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Osteoporosis					
Stroke					
Thyroid Disease					
Other:					

Health Habits

	Yes	No	Quit
Do you smoke or use any tobacco products?	*Form of tobacco used:*		
Do you use recreational/street drugs?			
Do you drink alcohol?			
Do you exercise or participate in physical activity on a regular basis?			

What types of exercise or physical activities have you enjoyed or currently enjoy?
____

Social History

Education: How many years of school have you completed? ____________________

Previous/current occupation: ____

Marital status: ❑ Single ❑ Married ❑ Living with significant other ❑ Divorced ❑ Widowed

Caregiver support: Do you have support at home to help you with your daily activities? Yes No

If yes, who helps you? _________________

Medications

Please list **<u>all</u>** medications you take, including prescription medications, inhalers, over the counter medications, vitamins/herbal supplements, injections and/or infusion medications.

Medication Name	Dosage

What pharmacy do you use for prescription medications? _______________________

Do you have assistance with managing medications? ❑ Yes ❑ No