Please complete the forms in this packet and bring to your first appointment.

PATIENT HEALTH HISTORY

UPMC LIFE CHANGING MEDICINE

Getting to Know You

We want you to feel connected to your PCP and everyone on your team. That's why we take the time to know you and those important to you. The next pages have forms with questions about you, your health, and your family's health. We ask about your health history because it helps your PCP know what you need now and what you might need in the future.

Please answer all of the questions and bring the papers with you to your first appointment. The forms you will fill out are listed below.

- **About Me**
- **My Health History**
- **My Medications**
- **HIPAA Form**
- **My Questions**

What you write on the forms is confidential. That means your information is not shared unless you give us permission or we need to by law. For example, we might share a test result with the hospital so you don't have to have the test again. Your new PCP office will give you a privacy notice. It lists who we share information with and why we share it. You can give other people permission to ask us about your health, too. Just fill out the HIPAA form in your packet and bring it to your visit.

Name:_____ **DOB:**_____

About Me

My legal name:_____
first middle last

My preferred name:_____ **My preferred pronoun:**_____

My birthday:_____ **My social security number:** _____
mm/dd/yyyy

My address: _____
number street

_____
city state zip code

My phone numbers:

_____ ☐ home ☐ work ☐ cell Detailed messages ok? ☐ yes ☐ no

_____ ☐ home ☐ work ☐ cell Detailed messages ok? ☐ yes ☐ no

_____ ☐ home ☐ work ☐ cell Detailed messages ok? ☐ yes ☐ no

My emergency contacts:

_____
name relationship phone number

_____
name relationship phone number

MY INSURANCE INFORMATION

My primary insurance company name: _____

Policy number: _____Group number: _____

Policyholder name: _____Relationship to you: _____

Claims address:_____

_____

My secondary insurance company name: _____

Policy number: _____Group number: _____

Policyholder name: _____Relationship to you: _____

Claims address:_____

_____

Name:_____ **DOB:**_____

How I Identify Myself

My legal gender: ☐ Male ☐ Female *(UPMC must send insurance bills using your legal gender)*

I am: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed ☐ Other

My ethnicity: ☐ Hispanic, Latino, or Spanish ☐ Not Hispanic, Latino, or Spanish ☐ Decline to answer

My current work status: ☐ Disabled ☐ Full-time ☐ Not Employed ☐ On Active Military Duty ☐ Part-time ☐ Retired ☐ Self Employed ☐ Student Full-time ☐ Student Part-time

Where I work/go to school: _____

What I do for work/school: _____

What I do for fun (hobbies): _____

I need an interpreter: ☐ Yes ☐ No

My preferred spoken language: _____

My preferred written language: _____

My faith/spiritual health needs: _____

My race *(choose all that describe you)***:**

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other: _____

☐ Decline to answer

My assigned sex at birth *(on my original birth certificate)***:** ☐ Male ☐ Female

My current gender identity: ☐ Male ☐ Female ☐ Transgender ☐ Something else:_____

My sexual orientation: ☐ Heterosexual (straight) ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Something else: _____

Name:_____ **DOB:**_____

My Allergies

☐ I am not allergic to anything ☐ I am allergic to some medicines ☐ I am allergic to some foods

☐ I have seasonal allergies (trees, animals, dust, weeds, etc.) ☐ I have other allergies

What I am allergic to:	What happens:	What I am allergic to:	What happens:

MY PHARMACY

Please tell us where your new PCP should send prescriptions if you need them.

Pharmacy name: _____

Address: _____
number street

_____
city state zip code

Phone number: _____ _____Fax number: _____

Pharmacy name: _____

Address: _____
number street

_____
city state zip code

Phone number: _____ _____Fax number: _____

Name:_____ **DOB:**_____

My Medications

Please tell us about the medicines you take now. Types of medicines to write down include:

- Prescriptions
- Vitamins
- Supplements
- Natural remedies
- Herbal remedies
- Other over-the-counter medicines

Name of medicine	Strength (Dose)	How many I take	How often / when I take it	Why I take it	When I started taking it
Example	*50 mg*	*1 pill*	*Twice a day (morning and bedtime)*	*For my high cholesterol*	*2010*

Name:_____ **DOB:**_____

Health Care Providers I Have Seen In The Past

Provider name: _____

Practice name: _____

Date last seen: _____ Reason seen: _____

Provider name: _____

Practice name: _____

Date last seen: _____ Reason seen: _____

Provider name: _____

Practice name: _____

Date last seen: _____ Reason seen: _____

Provider name: _____

Practice name: _____

Date last seen: _____ Reason seen: _____

Provider name: _____

Practice name: _____

Date last seen: _____ Reason seen: _____

MY HOSPITAL STAYS

Please write down any time you have been in the hospital for one night or longer.

Reason for hospital stay	**Year**	**Reason for hospital stay**	**Year**

Name:_____ **DOB:**_____

My Medical History

If you have a health problem below now or had it before, write the year the problem started.

Condition	Year	Condition	Year	Condition	Year
Abnormal PAP smear		Eczema		Obesity	
ADD/ADHD		Failure to thrive		Otitis media *(recurrent)*	
Allergic rhinitis		GERD *(reflux/heartburn)*		Pneumonia	
Allergies		Headache		Scoliosis	
Anemia		Hearing loss		Seizures	
Anxiety disorder		Heart murmur		Sickle cell anemia	
Arthritis		HIV/AIDS		Strep throat *(recurrent)*	
Asthma		Inflammatory bowel disease		Substance abuse	
Cancer		Jaundice		Tuberculosis	
Clotting disorder		Kidney disease		UTI *(urinary tract infection)*	
Depression		Lead poisoning		Varicella *(chicken pox)*	
Diabetes mellitus		Meningitis		Vision problems	
Eating disorder				Other:	
				Other:	
				Other:	
				Other:	
				Other:	

Name:_____ **DOB:**_____

MY SURGERY HISTORY:

If you have had a surgery below, write the year of the surgery

Surgery	Year	Surgery	Year	Surgery	Year
Adenoidectomy (adenoids)		Eye surgery		Lymph node biopsy	
Appendectomy (appendix)		Fracture surgery		Mastectomy	
Brain surgery		Gastrostomy		Small intestine surgery	
Breast surgery		Heart surgery		Spine surgery	
CABG (open heart surgery)		Hernia repair		Tubal ligation	
Cholecystectomy		Hysterectomy		Umbilical hernia repair	
Colon surgery		Inguinal hernia repair		Valve replacement	
Cosmetic surgery		Joint replacement		VP shunt	
Cesarean section				Other:	
				Other:	
				Other:	
				Other:	
				Other:	
				Other:	
				Other:	
				Other:	

Name:_____ **DOB:**_____

MY FAMILY HISTORY:

Put an "X" in the box if someone in your family has ever had a health problem below.

Family Member	Alcohol abuse	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Drug abuse	Early death	Hearing loss	Heart disease	High cholesterol	Hypertension (high blood pressure)	Intellectual Disability	Kidney disease	Learning disabilities	Mental illnesses	Miscarriages/stillbirth	Stroke	Vision loss
Mother																					
Father																					
Sister																					
Brother																					
Daughter																					
Son																					
Mom's sister																					
Mom's brother																					
Dad's sister																					
Dad's brother																					
Mom's mom																					
Mom's dad																					
Dad's mom																					
Dad's dad																					
Other:																					
Other:																					
Other:																					
Other:																					
Other:																					

☐ **Adopted**

☐ **Family history unknown**

Name:_____ **DOB:**_____

MY TOBACCO USE:

- ☐ Never Smoker
- ☐ Passive Smoke Exposure (Second Hand Smoke; Never Smoker)
- ☐ Former Smoker
  - Start date: _____
  - Packs per day: _____(estimate)
  - Quit date:_____
- ☐ Current Every Day Smoker
  - Start date:_____
  - Packs per day: _____
- ☐ I use tobacco and I want to quit
- ☐ I use tobacco and I do not want to quit

Type of tobacco I use(d): ☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless (chew/snuff)

☐ other:

My alcohol use: ☐ I drink alcohol ☐ I do not drink alcohol

How much alcohol I drink:

_____ glasses of wine per week
_____ cans of beer per week
_____ shots of liquor per week
_____ standard drinks or equivalent per week

My illegal drug use:

- ☐ I use drugs and I want to quit
- ☐ I use drugs and I do not want to quit
- ☐ I quit using drugs
- ☐ I have never used drugs or tried them once or twice
- ☐ I have never used drugs

What illegal drugs I use(d):_____

How much I use(d): ☐ pills ☐ injections ☐ times Every: ☐ day ☐ week

When I started/quit: Year I started:_____Year I quit: _____

Name:_____ **DOB:**_____

MY SEXUAL HISTORY

My current sex partners:
☐ I have never had a sex partner ☐ I have had one or more sex partners
☐ I don't have a partner ☐ I have one partner ☐ I have many partners

My partners are/were:
☐ men ☐ women ☐ both men and women

My birth control/protection:
☐ abstinence ☐ pulling out (coitus interruptus) ☐ condom male
☐ condom female ☐ diaphragm ☐ emergency contraceptive ☐ implant
☐ injection ☐ inserts ☐ IUD ☐ the pill (oral contraceptive: OCP)
☐ patch ☐ post-menopausal ☐ rhythm method ☐ spermicide
☐ sponge ☐ surgical vasectomy/tubes tied ☐ ring ☐ none
☐ something else:

OTHER THINGS ABOUT ME:

I live with (choose all that apply):
☐ I live alone ☐ Spouse/significant other ☐ Child/children
☐ Friends/family ☐ Parents ☐ Someone else:

Over the last two weeks how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

My exercise:

I follow exercise recommendations:
☐ Yes ☐ No

My exercise is limited by:
☐ Physical limitations
☐ Pain or discomfort
☐ No limitations
☐ Other:

I believe my physical activity level is:
☐ Sedentary or inactive
☐ Adequate
☐ Moderate
☐ Vigorous or very active

What I do for exercise (describe):_____

Name:_____ **DOB:**_____

MY DIET

☐ I do not have a specific diet
☐ Diabetic diet ☐ Cardiac ☐ Gluten free ☐ High fiber ☐ Lactose free

☐ Low carb ☐ Low fat ☐ Mechanical soft ☐ PKU–phenylketonuria diet
☐ Puree ☐ Renal ☐ Vegan ☐ Vegetarian

☐ Something else:

My caffeine use: ☐ I do eat/drink things with caffeine ☐ I don't eat/drink things with caffeine

Things I eat/drink with caffeine: _____

How much I eat/drink them: _____

About me:

I have trouble hearing. ☐ Yes ☐ No

I wear hearing aids. ☐ Yes ☐ No

I am blind or have trouble seeing. ☐ Yes ☐ No

I wear glasses and/or contacts. ☐ Yes ☐ No

I have a health condition that makes it hard for me to concentrate, remember, or make decisions. ☐ Yes ☐ No

I sometimes have trouble paying for the care I need. ☐ Yes ☐ No

MY HEALTH WISHES

Health wishes:
☐ I agree to discuss end of life wishes with my health care provider
☐ I do not agree to discuss end of life wishes with my health care provider

I already have health wishes in writing:
☐ I have an advanced directive / living will
☐ Durable medical power of attorney
☐ Durable financial power of attorney
☐ Health care proxy
☐ POLST (Physician Order for Life-Sustaining Treatment)
☐ Something else:

Please bring a copy of any health wishes you have in writing. We will put them in your medical record. If you want your wishes in writing, ask us for information during your visit.

Name:_____ **DOB:**_____

MY VACCINES AND SHOTS

Tetanus (Tdap)	Date:_____	Shingles vaccine_____	Date:_____
Tetanus (Td)	Date:_____	Hepatitis A _____	Date:_____
Pneumonia (Prevnar 13)	Date:_____	Hepatitis B _____	Date:_____
Pneumonia (Pneumovax)	Date: _____	Other:_____	Date: _____
Flu shot	Date: _____	Other:_____	Date: _____

MY EXAMS AND TESTS

Exam or test	Date	Result		
Yearly physical	_____	☐ Normal	☐ Not normal	☐ Not sure
Eye exam	_____	☐ Normal	☐ Not normal	☐ Not sure
Hearing test	_____	☐ Normal	☐ Not normal	☐ Not sure
Dental visit	_____	☐ Normal	☐ Not normal	☐ Not sure
Cholesterol check	_____	☐ Normal	☐ Not normal	☐ Not sure
Blood sugar check	_____	☐ Normal	☐ Not normal	☐ Not sure
Colonoscopy or stool test	_____	☐ Normal	☐ Not normal	☐ Not sure
Hepatitis C screening (blood)	_____	☐ Normal	☐ Not normal	☐ Not sure
Prostate exam	_____	☐ Normal	☐ Not normal	☐ Not sure
Pap smear	_____	☐ Normal	☐ Not normal	☐ Not sure
Mammogram	_____	☐ Normal	☐ Not normal	☐ Not sure
DEXA scan (bone density)	_____	☐ Normal	☐ Not normal	☐ Not sure
Other:	_____	☐ Normal	☐ Not normal	☐ Not sure
Other:	_____	☐ Normal	☐ Not normal	☐ Not sure
Other:	_____	☐ Normal	☐ Not normal	☐ Not sure

What should we know about your health?

_____

_____

_____

_____

_____

Name:_____ **DOB:**_____

My Questions

During your visit, you might have questions. Please ask them! We want to help you know as much as you want to know about your health.

Write any questions you have below and bring this paper to your visit.

QUESTIONS ABOUT MY HEALTH

1._____

2. _____

3. _____

QUESTIONS ABOUT MY MEDICINE

1._____

2. _____

3. _____

OTHER QUESTIONS I HAVE

1._____

2. _____

3. _____

MY NOTES

_____

_____

_____

_____

_____

_____

_____

_____