Garner Family Practice
801 Poole Drive
Garner, NC 27529

HEALTH HISTORY ASSESSMENT

Date: _____ Primary Care Physician: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Work Phone #_____ Mobile Phone#_____

Email address: _____

Employer: _____ Occupation: _____
If retired, what was your previous occupation? _____

Gender:	Marital Status:	Ethnicity:	Race:	Preferred Language:
Male ☐	Single ☐	Hispanic/Latino ☐	Asian ☐	English ☐
Female ☐	Married ☐	Not Hispanic/Latino ☐	American Indian ☐	Spanish ☐
	Divorced ☐	Decline ☐	Black/African American ☐	Other_____
	Domestic Partner ☐		Native Hawaiian ☐	
	Widowed ☐		White/Caucasian ☐	
			Decline ☐	

How confident are you that you can manage and control any health problems or concerns?
☐ Very confident ☐ Somewhat confident ☐ Not confident
Do you have a healthcare proxy/legal guardian? _____ If so, please provide name_____
Do you have an advance directive? ☐ Living will ☐ Healthcare power of attorney ☐ No
If yes, please provide a copy for your health record. If no, do you have a specific end of life care preference?
_____

Allergies (medicine, food, latex, etc.)/Reactions_____
_____

Current Medications (Include medications taken for sleep and as a laxative)

Medication	Dose	Frequency Taken	Medication	Dose	Frequency Taken

List Previous and Current Conditions Being Treated for (ex. High blood pressure, diabetes): _____
_____
_____

List Surgeries/Hospitalizations with Dates: _____
_____
_____