PRIMARY CARE MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Patient Health History - Indicate if you have had any of the following conditions or diagnosis and the approximate date of onset by month & year. If the date is unknown, please indicate the approximate age of onset.

ILLNESS	DATE	ILLNESS	DATE	ILLNESS	DATE
ADDICTION		EMPHYSEMA		LUPUS	
AIDS or HIV		EPILEPSY		MIGRAINES w/ ORAS	
ANEMIA		FIBROMYALGIA		MONONUCLEOSIS	
ANXIETY		GASTROINTESTINAL		OSTEOPOROSIS	
APPENDICITIS		GERD		PNEUMONIA	
ARTHRITIS		GLAUCOMA		PSYCHIATRIC DIAGNOSIS	
ASTHMA / ALLERGIES		GOUT		RUBELLA	
BLOOD CLOTS		HEART DISEASE		STD's / STI's	
CANCER		HEPATITIS		STOMACH ULCERS	
CARDIAC DISEASE		HIGH BLOOD PRESSURE		STROKE	
CHICKEN POX		HIGH CHOLESTEROL		THYROID PROBLEMS	
DEPRESSION		KIDNEY / BLADDER		TUBERCULOSIS	
DIABETES		LIVER DISEASE		WHOOPING COUGH	
EATING DISORDER(S)		LUNG DISEASE		OTHER:	

HOSPITALIZATION & SURGERY HISTORY - Please indicate any reason for hospitalization including childbirth and approximate date

HOSPITALIZATION or SURGERY	DATE	HOSPITALIZATION or SURGERY	DATE

Date of Last Period - Please indicate the start of your last menstrual cycle, if you are currently pregnant or breast feeding in notes

Date:	Duration:	Are you regular? YES NO	Notes:
Currently Sexually Active?	YES NO Notes_____	Current Birth Control Method:	

DRUG ALLERGIES - Please list any medication to which you are allergic

SOCIAL HISTORY -

Do you exercise? YES NO	Explain:	Do you follow a diet? YES NO	Explain:

Please indicate if you have used any of the following substances and, if so, when & how much

SUSTANCE	FREQUENCY	DURATION	CONCLUSION
ALCOHOL: YES NO	DRINKS PER WEEK?	FOR HOW MANY YEARS	DISCONTINUED WHEN
CAFFEINE: YES NO	OUNCES PER DAY?	FOR HOW MANY YEARS	DISCONTINUED WHEN
TOBACCO: YES NO	PACKS PER DAY?	FOR HOW MANY YEARS	DISCONTINUED WHEN
STREET DRUG: YES NO	FREQUENCY?	FOR HOW MANY YEARS	DISCONTINUED WHEN
TYPE OF DRUG:	1)	2)	3)

PREVENTATIVE CARE - Please indicate the last time you had the following (list mm/dd/yyyy)

EXAM / VACCINE	DATE	EXAM / VACCINE	DATE
LIPID PROFILE		PAP SMEAR	
EYE EXAM		BREAST EXAM	
FLU SHOT		MAMMOGRAM	
COLONOSCOPY		PROSTATE EXAM	

Family Health History - Please indicate if any of your blood relatives currently have or have had any of these conditions

ILLNESS	RELATION	ILLNESS	RELATION
ARTHRITIS		GLAUCOMA / EYE DISEASE	
ASTHMA		HEART DISEASE	
BLEEDING DISORDER		HIGH BLOOD PRESSURE	
BOWEL DISORDER		KIDNEY DISEASE	
CANCER		LUNG DISEASE	
CHEMICAL DEPENDENCY		PSYCHIATRIC CARE	
DEPRESSION		STROKE / TIA	
DIABETES		THYROID PROBLEMS	
EPILEPSY / CONVULSIONS		OTHER:	

Is there anything else you would like to talk to your provider about?

_____

_____

_____

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, HERBAL AND VITAMIN SUPPLEMENTS.

MEDICATION NAME	**START / STOP DATE**	**DOSAGE**	**FREQUENCY** _____ X/DAY	**ROUTE** ORAL, NASAL, PATCH, TOPICAL, IV, OTHER	**REASON / NOTE**
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