PRIMARY MEDICAL

PATIENT MEDICAL HISTORY

Name:_____ **Birthdate:** _____ **Today's Date:** _____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES? YES NO

If yes, describe:

_____

_____

MEDICATIONS

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

IMMUNIZATIONS

	Date
Tetanus, diphtheria and pertussis (Tdap)	
Pneumonia, Prevnar 13	
Pneumonia, Pneumovax 23	
Influenza in the last 12 months	
COVID 19 Vaccine ❑ Pfizer ❑ Moderna ❑ Johnson and Johnson	
Shingles, Shingrix (indicate both doses)	
Other?	

FAMILY HISTORY OF MEDICAL CONDITIONS

FATHER	
MOTHER	
BROTHER	
SISTER	
CHILDREN	
OTHER	

SOCIAL HISTORY

Do you exercise regularly? Yes/ No Light level: Less than 3 times per week____ Moderate level :3 times per week____ Strenuous level: More than 3 times per week_____	Do you smoke or use tobacco? Yes No If yes, how many packs per day? _____ Did you ever smoke? Yes No If yes, when did you quit? _____ How many packs per day? _____ Number of years? _____
Marital Status: S M W D # of Children: _____	
Work Status: Part-time Full-time Unemployed Retired Occupation:_____	Do you use recreational drugs? Yes No If yes, which drugs:_____ How much and How often: _____
Are you sexually active? Yes No	Do you have a POLST? Yes No
Do you drink alcohol? Yes No What types?: Beer Wine Hard Liquor Do you drink 3 or more drinks per day? Yes No	Do you have an Advanced Directive? Yes No

PLEASE CHECK SURGERIES OR PROCEDURES WITH DATES:

	Date		**Date**		**Date**
Cataract		Breast Biopsy		Spinal/Neck Surgery	
Adenoid		Breast Lumpectomy		Kidney Transplant	
Ear Surgery		Breast Augmentation		Urinary Bladder Surg.	
Sinus Surgery		Mastectomy		Prostatectomy	
Thyroid Surgery		Appendectomy		Vasectomy	
Tonsillectomy		Gallbladder		Hysterectomy	
Lung Surgery		Hernia Repair		Tubal Ligation	
Artery/Vein Surgery		Intestinal Surgery Please list:		Cesarean Delivery	

Cardiovascular Surgery				Back Surgery Please List:	
Carotid Endarterectomy		Joint Replacement Please List:			
Coronary Artery Surgery				Other:	
Breast Surgery					

PLEASE CHECK ILLNESSES OR CONDITIONS YOU HAVE HAD:

	Abnormal Mammogram		Dementia		Lung Cancer
	Abnormal Pap/HPV		Depression		Lymphoma
	Anxiety		Diabetes Mellitus-Gestational		Mental Disorder
	Arthritis		Diverticulosis or Diverticulitis		Migraines
	Asthma		Gout		Osteoporosis
	Blood Clots/DVT		Hyperlipidemia		Prostate Cancer
	Breast Cancer		Hypertension		Seasonal or Environmental Allergy
	COPD/Emphysema		Hyperthyroid		Sexually Transmitted Infection
	Cancer:_____		Hypothyroid		Stroke
	Cardiovascular Disease		Irritable Bowel Disease		Thyroid Cancer
	Colon Cancer		Kidney Disease		Tuberculosis
	Crohn's Disease or Ulcerative Colitis		Leukemia		Other:

PREVENTATIVE SCREENINGS - Date of last exam:

Mammogram: _____ Colonoscopy: _____

Pap Smear: _____ Foot Exam (Diabetics): _____

Dexa Scan (Bone density): _____ Complete Physical: _____

Eye Exam_____

Signature_____ Date _____