PrimeCare
URGENT & FAMILY CARE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible.

PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

MEDICAL HISTORY

Please list any medication allergies or reactions:

_____ _____

_____ _____

_____ _____

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

Arrythmia	Emphysema	Seizures
Asthma	Eye Problems*	Sexually Transmitted Disease*
Cancer*	Heart Attack	Stroke
Coronary Artery Disease	Hepatitis	Tuberculosis
Depression	High Blood Pressure	Thyroid
Diabetes	Kidney Disease	

Other and conditions circled with asterisks (*), please explain:

_____

_____

_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

_____ _____

_____ _____

_____ _____

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____ Living children: _____

Do you have regular periods? ___Yes ___No

If no, please explain: _____

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Please list <u>all</u> medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Provider's name	*Condition they are treating you for*
_____	_____
_____	_____
_____	_____

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Influenza	_____	Hepatitis B	_____
Tetanus	_____	Other, name & date:	_____
Pneumonia	_____	Other, name & date:	_____

Please note when the following tests done, if applicable, and what the results were, if known:

Cholesterol	_____	HIV	_____
Pap smear/pelvic	_____	Colonoscopy	_____
Mammogram	_____	Hepatitis C	_____
Blood in stool	_____		

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FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother mother's side)	Grandfather mother's side)	Grandmother father's side)	Grandfather father's side)	Child	Other Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments Regarding Family History:

_____

_____

_____

_____

_____

_____

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SOCIAL HISTORY

Please check yes/no for each question and explain as necessary:

Do you smoke or use any tobacco products? ___Yes ___No

Number of cigarettes each day? _____ Types of tobacco used? _____

For how many years? _____ Quit smoking, date: _____

How much alcohol do you drink? _____ How often? _____

Have you ever felt you should cut down on drinking? ___Yes ___No

Have you regularly used drugs? ___Yes ___No

If yes, what kind? _____ If yes, are you still using them? ___Yes ___No

Are you currently married or living with a significant other? _____

Who lives with you at home? _____

How many children do you have? _____

Are you employed? ___Yes ___No Occupation: _____

Do you ever feel sad or depressed? ___Yes ___No

Any financial issues limiting access to food, shelter, or medical care? ___Yes ___No

Any major life changes within the last year? ___Yes ___No
(i.e. marriage, divorce, death of loved one, illness/injury, or job change)

Do you have some form of church or spiritual support? ___Yes ___No

Sexual Preference: ___Women ___Men ___Both

Do you use any form of birth control? ___Yes ___No If yes, what type? _____

Do you feel you are at risk for HIV/AIDS? ___Yes ___No