Primary Care Medical Associates Ltd.

NEW PATIENT HEALTH HISTORY

Name_______________________________________ **Date of Birth**_________________

Date_______________________________________

Referred By: ________________________________

Allergies: List any drugs/food/other you are allergic to (what was the reaction?):

____
____
____

Please state the purpose of your visit today, and what your concerns are:

____
____

List major illnesses, present and past		
Surgical History		
Type of Surgery	**Year**	**Where Treated**

Social History

Marital Status				
Occupation				
Hobbies				
Habits	Yes	No		Quit Date
Tobacco			Packs per day: When started:	
Alcohol			Drinks per week: Type:	
Caffeine			Cups per day:	
Drug Use			Type:	
Exercise			Activity & times per week	

Gynecologic History (female patients)

Last Menstrual Period: ____________________________________
Menopausal/Post Menopausal (circle one if applicable)
Pregnancies: _____ **Births:** _____ **Miscarriages:** _____ **Abortions:** _____

Medications – Please list prescription medications, over the counter medications, vitamins, herbal supplements, etc.

Name of Medicine	Dose	How Often	Reason

Screening Exams	List date of last exam or put none if never done
Eye Exam	
Colonoscopy	
Dental Exam	
Bone Density/DEXA scan	
HIV testing	
Men only: Prostate Specific Antigen (PSA)	
Women only: Mammogram	
Pap Smear	
History of Abnormal Pap Yes/No	

Family History

Relation	Age	Medical Illness	Age at death	Cause of death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				
Child				
Has any blood relative (grandparent/ uncle/ aunt etc.) ever had If so, list who and what type below			Cancer: Yes Diabetes: Yes Heart Disease: Yes	

Immunizations

Name of Vaccine	Date last given	Name of Vaccine	Date last given
Tetanus or Tdap		Gardasil(cervicalcancer)	
Influenza (flu)		Hepatitis A	
Pneumovax (pneumonia)		Hepatitis B	
Zostavax (shingles)		PPD (tuberculosis)	

List any other vaccines given in the past: ____

List any other medical or alternative providers by name, specialty and reason that you see them

Name	Specialty/Reason

Review of Systems

Please circle No or Yes to the following symptoms if you are currently having them or have experienced them in the past few months:

Fevers/Chills	No/Yes	Burning w/urination	No/Yes
Weight Loss	No/Yes	Frequency	No/Yes
Weight Gain	No/Yes	Blood in urine	No/Yes
Loss of Appetite	No/Yes	Headaches	No/Yes
Night Sweats	No/Yes	Vision changes	No/Yes
Shortness of Breath	No/Yes	Joint/Muscle Pain	No/Yes
Cough	No/Yes	Bruise easily	No/Yes
Chest Pain	No/Yes	Irregular periods	No/Yes
Palpitations	No/Yes	Vaginal discharge	No/Yes
Nausea/vomiting	No/Yes		
Diarrhea	No/Yes		
Abdominal Pain	No/Yes		
Constipation	No/Yes		
Heartburn	No/Yes		

Your provider will review the above information at your first visit.