Name: _____ **DOB**: _____

Previous Medical Providers name and address: _____

_____

ALLERGIES:

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY**:**

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS, SURGERIES

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No If yes did you have any reaction? ☐ Yes ☐ No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN: **COMMENTS;**

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If, yes answer questions below.

- Ever tried to cut back on the amount of alcohol you drink? ☐ Yes ☐ No
- Ever become angry when people discuss your alcohol? ☐ Yes ☐ No
- Ever felt guilty about anything you did because of your drinking? ☐ Yes ☐ No
- Ever had a drink before noon (eye opener)? ☐ Yes ☐ No
- Has your drinking affected your relationship with your family or friends? ☐ Yes ☐ No
- Has your drinking affected your work or school? ☐ Yes ☐ No
- Have you ever drunk alcohol while or before driving or driven while intoxicated? ☐ Yes ☐ No

Do you drink coffee, sodas or other caffeinated beverages? ☐ Yes ☐ No

Do you use any street drugs or abuse prescription pain medication? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How Often? _____ Sleep regular hours? ☐ Yes ☐ No How many?_____

Weight one year ago: _____ Weight 5 years ago: _____ Diet to lose weight? ☐ Yes ☐ No How many times?_____

SOCIAL HISTORY

Do you think you are at risk for HIV, AIDS or other sexually Transmitted disease? ☐ Yes ☐ No

Have you ever been tested for HIV? ☐ Yes ☐ No

If yes, when _____. What was the Result? ____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other: _____

Occupation: _____ Do you have an Advance Directive? ☐ Yes ☐ No

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		☐ Alive ☐ Deceased		
Mother		☐ Alive ☐ Deceased		
1. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
2. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
3. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
4. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		

CAPITAL PRIMARY CARE

FAMILY HISTORY			RELATIVE				RELATIVE
1. Alzheimer's Disease	☐ Yes	☐ No	_____	11. Iron Storage Disease	☐ Yes	☐ No	_____
2. Breast Cancer	☐ Yes	☐ No	_____	12. High Blood Pressure	☐ Yes	☐ No	_____
3. Heart Disease	☐ Yes	☐ No	_____	13. Ovarian Cancer	☐ Yes	☐ No	_____
4. Stroke	☐ Yes	☐ No	_____	14. Prostate Cancer	☐ Yes	☐ No	_____
5. Depression, Suicide	☐ Yes	☐ No	_____	15. Skin Cancer	☐ Yes	☐ No	_____
6. Diabetes	☐ Yes	☐ No	_____	16. Thyroid Disease	☐ Yes	☐ No	_____
7. High Cholesterol	☐ Yes	☐ No	_____	17. Sickle Cell Disease	☐ Yes	☐ No	_____
8. Obesity	☐ Yes	☐ No	_____	18. Anemia	☐ Yes	☐ No	_____
9. Glaucoma	☐ Yes	☐ No	_____	19. Macular degeneration	☐ Yes	☐ No	_____
10. Substance Abuse	☐ Yes	☐ No	_____	20. Other:			_____

HEALTH MAINTENANCE

Last Stools, occult blood test: _____ Colonoscopy/Sigmoidoscopy: _____

Dental Exam: _____ Dilated Eye Exam: _____ Foot Exam: _____ Hearing Exam: _____

WOMEN: Last: PAP smear: _____ Mammogram: _____ Breast Exam: _____ Menstrual Period: _____

MEN: Last: Rectal/Prostate exam: _____ Testicular Exam: _____ PSA: _____

IMMUNIZATIONS: (last date/year received) Tetanus: _____ Hepatitis B vaccine: _____ MMR: _____

Pneumonia: _____ Flu:_____ Tuberculosis Skin Test (date & results): _____ Other:_____

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

CONSTITUTIONAl			SKIN			MUSCULO-SKELETAL		
Unexplained weight loss	☐ Yes	☐ No	Skin mole changes	☐ Yes	☐ No	Neck pain	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No	New skin lesions	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Fevers	☐ Yes	☐ No	Skin dry or itching	☐ Yes	☐ No	Injury to limbs	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Rashes	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Skin lesion removal	☐ Yes	☐ No	Joint stiffness in morning	☐ Yes	☐ No
Sweats at night	☐ Yes	☐ No	GASTROINTESTINAL			Locking or weak joints	☐ Yes	☐ No
Eyes			Blood in stool	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Cataract	☐ Yes	☐ No	Change in movements	☐ Yes	☐ No	Red or Swollen joints	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	HEMATOLOGY/ONCOLOGY		
Glasses	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Anemia or low blood	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No	Difficulty swallowing	☐ Yes	☐ No	Easily bruise	☐ Yes	☐ No
ENMT			Heart burn	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No
Bleeding from gums	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No	Cancers	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No	Abdominal pain or lump	☐ Yes	☐ No	PSYCHIATRIC		
Change in your voice	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No	Depression or Sadness	☐ Yes	☐ No
Nasal blockage	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No	Problems with anger	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	GENITOURINARY			Obsessive thoughts	☐ Yes	☐ No
Frequent sneezing	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No	Compulsive behavior	☐ Yes	☐ No
Sinus infections	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No	Urinary infections	☐ Yes	☐ No	Problems concentrating	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No	Loss of bladder control	☐ Yes	☐ No	Problems sleeping	☐ Yes	☐ No
CARDIOVASCULAR			Urination at night	☐ Yes	☐ No	NEUROLOGY		
Fainting spells	☐ Yes	☐ No	Sexual transmitted Ds	☐ Yes	☐ No	Memory loss	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Urge to urinate	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	WOMEN ONLY			Headaches	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No	Heavy or irregular cycle	☐ Yes	☐ No	Weakness of limb	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No	Vaginal dryness	☐ Yes	☐ No	Numbness of limb	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No	Pain with intercourse	☐ Yes	☐ No	History of stroke	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No	Vaginal discharge	☐ Yes	☐ No	Tremors	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No	Pain in breast	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No	Lumps in breast	☐ Yes	☐ No	ENDOCRINE		
RESPIRATORY			Nipple discharge	☐ Yes	☐ No	Intolerant of heat	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No	MEN ONLY			Intolerant of cold	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Problems with erections	☐ Yes	☐ No	Swelling or lump in neck	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No	Dribbling of urine	☐ Yes	☐ No	Excessive urination	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Weak urine stream	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Lung infections	☐ Yes	☐ No	Pain or lump in testicles	☐ Yes	☐ No	Changes in hair	☐ Yes	☐ No