PRIMARY CARE ASSOCIATES of Appleton, LTD

Patient Name: _____ **Date of Birth:**_____

Date: _____

PAST MEDICAL HISTORY

A. Have you ever been told that you had any of the following illnesses?

Condition	Yes	No	Comments
High Blood Pressure			
Heart Problems (Heart attack, heart failure, angina, atrial fibrillation…etc)			
Elevated Cholesterol			
Diabetes			
Thyroid Disease			
Gout			
Stroke or TIA (mini- stroke)			
Cancer (if yes what type?)			
Seizure Disorder			
Lung Disease /Asthma/COPD/Emphysema			
Hay Fever, Allergies			
Pneumonia			
Anemia			
Arthritis			
Psychiatric Conditions (Depression, Anxiety, Panic Disorder, ADHD)			
Blood Disorders or Bleeding Disorders			
Deep Vein Thrombosis (Blood Clots)/Clotting Disorder			
Reflux (GERD)			
Crohns Disease or Ulcerative Colitis			
Skin Disorders			
Hepatitis/Liver Disease			
Peptic Ulcer Disease (stomach ulcers)			
Rheumatic Fever			
Fractured Bones or other Serious Injuries			
Sexually Transmitted Diseases			
Sleep Apnea			
Migraines			
Osteoperosis			
Colon Polyps			

B. Have you ever had Surgery? Please provide details below:

Surgery	Year

C. List all medications, prescriptions and over-the-counter medications and supplements:

Name	Dosage and Frequency

D. Allergies (Medications and Food)

Name	Reaction

E. Family Medical History

Family History	Living	Deceased, age at death & cause	Have you or any blood relative ever had:	Yes	Who
Mother			Diabetes		
Father			High Blood Pressure		
Brother/Sister			Heart Trouble		
Brother/Sister			Stroke		
Brother/Sister			Migraine Headaches		
Son/Daughter			Psychiatric Problem		
Son/Daughter			Elevated Cholesterol		
Son/Daughter			Cancer		
			Bleeding Problem		
			Arthritis		
			Tuberculosis		
			Lung Disease		
			Asthma or Hay Fever		

F. Lifestyle

a. Smoking
   i. Have you ever smoked? Yes_____ No _____ If no, please go to part b.
   ii. Do you smoke now? Yes_____ No _____
   If No, when did you quit? _____
   How many years did you smoke?
   iii. If Yes, how much do you smoke in a typical day? _____

b. Drinking/Drug Use
   i. How much of the following beverages do you usually drink in a typical day?
   Coffee_____ Tea_____ Cola-Type Drinks_____
   Milk_____
   Alcoholic Beverages (wine, beer, liquor) Ounces per week_____
   ii. Have you ever used illicit/street drugs (marijuana, cocaine, crack, LSD, etc)
   If yes, please explain_____

c. Exercise
   i. Do you have a regular exercise schedule? Yes_____ No_____
   1. If yes, what type of exercise, how long and how often?_____

G. Social History

a. What is your marital status?
   Married_____ Separated_____ Widow_____
   Divorced_____ Single_____ Widower_____

b. With whom do you live? _____
c. What type of work do you do?_____
d. If retired, what were your occupations?_____

H. Routine Health Maintenance

a. When was your last Tetanus vaccine?_____
b. Have you ever received a Pneumovax (Pneumonia Shot?).
   i. If yes, please provide date:_____
c. Have you ever received Zostavax (shingles vaccine)?
   i. If yes, please provide date:_____
d. Have you ever had a Colonoscopy?
   i. If yes, please provide date of last exam and findings:_____
e. Women
   i. Date of last Mammogram?_____
   ii. Date of last Pap?_____
   iii. Have you ever had a bone density test (Dexascan)?
   1. If yes, date of last scan?_____
   iv. Do you perform monthly self breast exams?_____
f. Men
   i. Date of last PSA? _____
   ii. Do you perform monthly self testicular exams?_____

I. Review of Systems (Check any which apply)

Endocrine
___Weight Loss
___Loss of appetite
___Intolerance of heat or cold
___Excessive thirst
___Weight gain
___Excessive fatigue
___Fever, sweats, chills

Preoperative
___Anesthetic Problems
___Bleeding Problems
___Transfusion Reaction

Skin
___Rash
___Color/texture change
___Change in hair/nails
___Concern about a
___Lump/mole/sore
___Easy bruising

Psychiatric or Emotional
___Trouble sleeping
___Cry easily
___Depressed
___Anxiety, Panic Attacks
___Concern about eating behavior
___Loss of interests
___Irritability

Head/Neurologic
___Headaches
___Dizziness
___Lightheadedness
___Blackouts
___Difficulty with memory
___Numbness/tingling
___Unexplained
___Weakness/clumsiness
___Tremor/shaking
___Speech difficulty

Eyes
___Glasses or contacts
___Double or blurred vision
___Discharge or irritation of the eyes

Ears
___Hearing Difficulty
___Ringing in the ears
___Ear pain/discharge
___Vertigo/Dizziness

Nose/Throat/Sinuses
___Allergy symptoms
___Nasal congestion
___Frequent runny nose
___Frequent sinus infections
___Hoarseness
___Recurrent sore throats

Mouth
___Mouth sores/bleeding gums
___Dentures
___Periodontal disease

Respiratory
___Cough frequently
___Wheezing
___Shortness of breath with exertion
___Snoring with breathing lapses

Heart/Circulation
___Chest Pain
___Irregular, fast or skipped beats
___Leg pain or cramps
___Swelling in feet and ankles
___Heart murmur

Gastrointestinal
___Trouble swallowing
___Heartburn, acid taste in mouth
___Nausea, vomiting
___Abdominal pain
___Change in bowel habits
___Constipation
___Diarrhea
___Black stools/ blood in stools
___Rectal pain/itching/hemorrhoids
___Have you had an EGD (scope of the stomach)

Urinary
___Burning or pain with urination
___Blood in urine
___Involuntary loss of urine
___Kidney stones
___Frequent Urination
___Nighttime urination (how often)
___Difficulty with emptying bladder

Genital
___Sexual problems or questions
___Sores or lumps on genitals
___Sexually transmitted diseases
___Fertility problems

Men
___Problems with impotence (Problems with erection)
___Trouble starting or stopping
___Stream when urinate
___Bladder does not feel empty
___Prostate disease

Women
___Problems with periods
___Premenstrual symptoms
___Abnormal vaginal discharge
___Pelvic pain/ pain with intercourse
___Breast lumps
___Nipple changes or discharge
___Concerns about menopause/symptoms
___Date of last menstrual period
___Present method of birth control if necessary_____

Musculoskeletal
___Back pain
___Neck pain
___Swelling of joints
___Other joint pain_____ OR
___Muscle pain/aches