PRIMARY CARE ASSOCIATES of Appleton, LTD

MEDICAL HISTORY FORM FOR Jessica Johnston-Rickert, MD NCMP

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

PAST MEDICAL HISTORY

Have you ever been told that you had any of the following illnesses? (circle if applicable)

High blood pressure
Elevated Cholesterol
Thyroid Disease
Diabetes
Stroke or TIA (mini-stroke)
Gout
Anemia
Lung Disease (Asthma/COPD/Emphysema)
Seizure Disorder
Psychiatric Conditions (Depression, Anxiety)
Hay Fever, Allergies
Deep Vein Thrombosis (Blood Clots/Clotting Disorder)
Arthritis
GI Problems
Blood Disorders or Bleeding Disorders
Hepatitis/Liver Disease
Reflux (GERD), IBS, Crohn's, Colitis, Ulcers
Fractured Bones or other serious injuries, Osteoporosis
Skin Disorders (Eczema, Psoriasis)
GYN Problems (Fibroids/Pelvic Pain/PCOS)
Rheumatic Fever
Urinary Problems (Frequent UTI/Stones/Incontinence)
Sexually Transmitted Diseases
Fibromyalgia or Chronic Fatigue
Headaches (Migraines, Tension)
Number of Pregnancies: _____
Cancer (If yes, what type?_____)
Heart problems (heart attack, heart failure, angina, atrial fibrillation, etc)
Other:_____

Have you ever had surgery? Please provide details below:

Surgery	Year

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

Name	Purpose of Medication	Dosage and Frequency	Side Effects

Allergies (Medications and Food)

Name	Reaction

Family Medical History

Circle condition if present in family history and list what relation(s) had/has this condition

Diabetes: _____ High Blood Pressure: _____

Heart Trouble: _____ Stroke: _____

Migraine Headaches: _____ Psychiatric Problem: _____

Elevated Cholesterol: _____ Cancer: _____

Bleeding Problem: _____ Arthritis: _____

Tuberculosis: _____ Lung Disease: _____

Asthma or Hay Fever: _____ Clots: _____

Skin Problems: _____ Abdominal Aortic Aneurysm (AAA): _____

Thyroid Disease: _____ Osteoporosis: _____

Lifestyle

Smoking

- Have you ever smoked/used tobacco chew? Yes_____ No_____
- Do you smoke/chew now? Yes_____ No_____ N/A_____
- How much do you smoke/chew in a typical day? Yes_____ No_____ N/A_____

Drinking/Drug Use

- How much alcohol do you usually drink in a typical day? _____
- Have you ever used illicit/street drugs (marijuana, cocaine, crack, LSD, etc)

  If yes, please explain _____

Exercise

- Do you have a regular exercise schedule? Yes_____ No_____
- If yes, what type of exercise, how many hours per week? _____

- Have you ever had any Physical/Sexual/Emotional Abuse? Yes_____ No_____

Social History

- What type of work do you do? _____
- Any church affiliation? _____
- What type of education do you have? _____
- What are your hobbies? _____

Routine Health Maintenance

- When was your last Tetanus vaccine? Yes_____ No_____

Have you ever received a:

- Pneumovax (Pneumonia Shot)?Yes_____ No_____
  If yes, please provide date:_____
- Flu Injection? Yes_____ No_____
  If yes, please provide date:_____
- Zostavax (shingles) Injection? Yes_____ No_____
  If yes, please provide date:_____
- Gardasill Injection? Yes_____ No_____
  If yes, please provide date:_____
- When was your last cholesterol test?_____
- When was your last blood sugar test?_____
- Last Eye Exam: Date: _____
- Have you ever had a Colonoscopy? Yes_____ No_____
  If yes, please provide date of last exam and findings:_____

Women

- Date of last Mammogram?_____
- Date of last Pap?_____ Do you have a history of abnormal paps?_____
- Have you ever had a bone density test (Dexascan)? Yes_____ No_____
  If yes, date of last scan?_____

Menstruation

- When was your last menstrual period?_____
- What is your current birth control method? _____ Any problems?_____

Men

- Date of last PSA?_____
- Do you perform monthly self testicular exams? Yes_____ No_____