PRIMARY CARE SPECIALISTS, LLC.
PATIENT MEDICAL HISTORY SHEET

Please PRINT ALL Information

PATIENT INFORMATION

Name _____
Last First Middle

Today's Date:_____/_____/_____ Social Security # _____-_____-_____ Date of Birth_____/_____/_____

WHICH OF THE FOLLOWING CONDITIONS ARE YOU CURRENTLY BEING TREATED OR HAVE BEEN TREATED FOR IN THE PAST (PLEASE CHECK)

- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Stroke
- ☐ Neurological problems
- ☐ Heart disease/Murmur/Angina
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Rheumatic Fever
- ☐ Heartburn (reflux)
- ☐ Liver problems/Hepatitis
- ☐ Ulcers/colitis
- ☐ Kidney/Bladder problems
- ☐ HIV/AIDS
- ☐ STD (sexually transmitted diseases)
- ☐ Asthma
- ☐ Lung problems/cough
- ☐ Seasonal Allergies
- ☐ Anemia or blood problems
- ☐ Blood clots
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Back problems
- ☐ Depression/Anxiety
- ☐ Drug/Alcohol Abuse
- ☐ Eye disorder/Glaucoma
- ☐ Cancer_____

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list_____

Medications

Please list_____

_____

_____

Immunizations (include dates)

Hepatitis A_____ Hepatitis B_____ Pneumonia_____ Influenza_____ TB test/results_____

DPT/Td (tetanus)_____ OPV (polio)_____ MMR (measles, mumps, rubella)_____ Varicella_____

Other_____

SOCIAL AND PREVENTIVE HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs a day?_____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many drinks per week?_____

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day?_____

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seatbelts while driving? ☐ Yes ☐ No Do you wear a helmet while riding a bike? ☐ Yes ☐ No

FAMILY HISTORY

	Living	Age (or age at death)	Cause of death
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Sister	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
Brother	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Has any member of your family (including children and parents) had any of the following illnesses

Illness	Which family member?
Anemia or Blood disease	
Cancer	
Diabetes	
Glaucoma	
Heart disease	
High blood pressure	
HIV disease / AIDS	
Mental Illness / Depression	
Stroke	
Kidney disease	
Liver disease	
Seizures	

FAMILY HISTORY CONTINUED

Illness	Which family member?
Thyroid	_____
Asthma	_____
Arthritis	_____
High cholesterol	_____
Other serious illness	_____

FEMALES: GYNECOLOGICAL HISTORY

How many times have you been pregnant?_____ Date of last Pap Smear_____

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis_____ Follow up_____

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis_____

Date of last mammogram_____ Mammogram results_____

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy results_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient/Legal Guardian Signature_____ **Date**_____