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

Symptom	Yes	No
Unexplained weight loss	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Sweats at night	☐ Yes	☐ No

Eyes

Symptom	Yes	No
Cataract	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No

ENMT

Symptom	Yes	No
Bleeding from gums	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No
Change in your voice	☐ Yes	☐ No
Nasal blockage	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Frequent sneezing	☐ Yes	☐ No
Sinus infections	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No

CARDIOVASCULAR

Symptom	Yes	No
Fainting spells	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No

RESPIRATORY

Symptom	Yes	No
Asthma or wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Lung infections	☐ Yes	☐ No

SKIN

Symptom	Yes	No
Skin mole changes	☐ Yes	☐ No
New skin lesions	☐ Yes	☐ No
Skin dry or itching	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Skin lesion removal	☐ Yes	☐ No

GASTROINTESTINAL

Symptom	Yes	No
Blood in stool	☐ Yes	☐ No
Change in movements	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Abdominal pain or lump	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No

GENITOURINARY

Symptom	Yes	No
Kidney Stones	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Urinary infections	☐ Yes	☐ No
Loss of bladder control	☐ Yes	☐ No
Urination at night	☐ Yes	☐ No
Sexual transmitted Ds	☐ Yes	☐ No
Urge to urinate	☐ Yes	☐ No

WOMEN ONLY

Symptom	Yes	No
Heavy or irregular cycle	☐ Yes	☐ No
Vaginal dryness	☐ Yes	☐ No
Pain with intercourse	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Pain in breast	☐ Yes	☐ No
Lumps in breast	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No

MEN ONLY

Symptom	Yes	No
Problems with erections	☐ Yes	☐ No
Dribbling of urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Pain or lump in testicles	☐ Yes	☐ No

MUSCULO-SKELETAL

Symptom	Yes	No
Neck pain	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Injury to limbs	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Joint stiffness in morning	☐ Yes	☐ No
Locking or weak joints	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Red or Swollen joints	☐ Yes	☐ No

HEMATOLOGY/ONCOLOGY

Symptom	Yes	No
Anemia or low blood	☐ Yes	☐ No
Easily bruise	☐ Yes	☐ No
Swollen lymph nodes	☐ Yes	☐ No
Cancers	☐ Yes	☐ No

PSYCHIATRIC

Symptom	Yes	No
Depression or Sadness	☐ Yes	☐ No
Problems with anger	☐ Yes	☐ No
Obsessive thoughts	☐ Yes	☐ No
Compulsive behavior	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Problems concentrating	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No

NEUROLOGY

Symptom	Yes	No
Memory loss	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Weakness of limb	☐ Yes	☐ No
Numbness of limb	☐ Yes	☐ No
History of stroke	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

ENDOCRINE

Symptom	Yes	No
Intolerant of heat	☐ Yes	☐ No
Intolerant of cold	☐ Yes	☐ No
Swelling or lump in neck	☐ Yes	☐ No
Excessive urination	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Changes in hair	☐ Yes	☐ No