UNIVERSITY PRIMARY CARE

Patient Medical History

Patient's Name: _____ DOB: ___/___/___ Who referred you? _____

What is the primary reason for today's visit? _____

_____

Medications (please bring all medications to every visit)

Please list: _____

_____

Allergies Are you allergic to any drugs? □Yes □No

Please list: _____

Social History

Right or **Left** handed

Do you currently smoke or chew tobacco? □Yes □No If yes, how many packs per day? _____

If no, have you in the past? □Yes □No When did you stop? _____

Do you drink alcohol, beer, or wine? □Yes □ No How many drinks per week? _____

If no, have you in the past? □Yes □ No If yes, when did you stop? _____

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

Do you or have you ever used illegal drugs? □Yes □No If yes, what drug and how often? _____

Do you exercise daily/weekly? □Yes □No

If yes, what type and how many times per week? _____

Current and Past Medical History (please check all that apply)

□Heart disease / Murmur / Angina □Shortness of breathe □Eye disorder / Glaucoma □Diabetes

□High cholesterol □Asthma □Seizures □Kidney / Bladder problems □High blood pressure

□Lung problems / Cough □Stroke □Liver problems / Hepatitis □Low blood pressure □Sinus problems

□Headaches / Migraines □Arthritis □Heartburn (reflux) □Seasonal Allergies □Neurological problems

□Cancer □Anemia / Blood problems □Tonsillitis □Depression / Anxiety □Ulcers / Colitis

□Swollen ankles □Ear problems □Psychiatric care □Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

_____

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Please list past hospitalizations and/or surgeries

_____

_____

Family History

Living Age (or age at death) List serious illnesses

Mother _____

Father _____

Sisters _____

Brothers _____

Illness – Which family member?

Anemia / Blood disease _____

Cancer _____

Diabetes _____

Glaucoma _____

Heart Disease _____

High blood pressure _____

HIV disease / AIDS _____

Mental illness / depression _____

Stroke _____

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 Results _____

Have you had a sexually transmitted disease? □Yes □ No Diagnosis _____

Date of last mammogram ___/___/___ Results _____

Have you ever had a breast biopsy? □Yes □No 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** ___/___/___

Physician signature _____ **Date** ___/___/___