erlanger Primary Care

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

Address: _____ Phone: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS ❑ NO MEDICATIONS

MEDICATION *(please list all)*	DOSE *(mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal result? Y N
Colonoscopy/Sigmoid	Date:	Facility/Provider:	Abnormal result? Y N
Mammogram	Date:	Facility/Provider:	Abnormal result? Y N
Pap Smear	Date:	Facility/Provider:	Abnormal result? Y N
Bone Density	Date:	Facility/Provider:	Abnormal result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	**Last Pnuemovax** *(Pneumonia)***:**
Last Flu Vaccine:	**Last Prevnar:**
Last Zoster Vaccine *(Shingles)***:**	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type: _____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type: _____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(Hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(Kidney)* Disease			
Migraine Headaches			
Stroke			
Other: _____			
Other: _____			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	**Age of First Menstruation: _____ Age of Menopause: _____**
Total Number of Pregnancies:	**Number of Live Births:**
Pregnancy Complications:	

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FAMILY MEDICAL HISTORY

❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer *(type: _____)*	Emphysema *(COPD)*	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	**Years of Education or Highest Degree:**
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____	
Do you have children? Y N **If yes, how many?** _____	

OTHER HEALTH ISSUES

TOBACCO USE	**Do you smoke cigarettes?** Y N *If you have never smoked, please continue to Alcohol/Drug Use.*
Current: Packs/day _____ # of Years _____	**Past:** Quit Date _____ Packs/day _____ # of Years _____
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew	
ALCOHOL/DRUG USE	**Do you drink alcohol?** Y N ❑ Beer ❑ Wine ❑ Liquor **# of Drinks/week** _____
Do you use marijuana or recreational drugs? Y N	**Have you ever used needles to inject drugs?** Y N
Have you ever taken someone else's drugs? Y N	

OTHER HEALTH ISSUES CONTINUED

SEXUAL HISTORY	Sexually involved currently? Y N *If no sexual history, please continue to Exercise.*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth Control Method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *If you answered no, please continue to Sleep.*	
What type of exercise?		**Duration:** How long (min) _____ How often _____
SLEEP	How many hours, on average, do you sleep at night (or during the day, if working night shift)? _____	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Order for Life Sustaining Therapy (POLST)? Y N		
Is violence at home a concern for you? Y N		

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiologist		
Gastroenterologist (GI)		
OB/GYN		
Neurologist		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N If yes, where? _____
Have you served in the military? Y N If yes, how long and what branch? _____
Were you deployed? Y N If yes, where? _____

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OTHER PROVIDERS/SPECIALISTS

CONSTITUTION	CARDIOVASCULAR	SKIN
❑ Activity Change	❑ Chest Pain	❑ Color Change
❑ Appetite Change	❑ Leg Swelling	❑ Pallor
❑ Chills	❑ Palpitations	❑ Rash
❑ Diaphoresis	**GASTROINTESTINAL**	❑ Wound
❑ Fatigue	❑ Abdominal Distention	**ALLERGY/IMMUNO**
❑ Fever	❑ Abdominal Pain	❑ Environmental Allergies
❑ Unexpected Weight Change	❑ Anal Bleeding	❑ Food Allergies
HEAD, EAR, NOSE, THROAT	❑ Blood in Stool	❑ Immunocompromised
❑ Congestion	❑ Constipation	**NEUROLOGICAL**
❑ Dental Problem	❑ Diarrhea	❑ Dizziness
❑ Drooling	❑ Nausea	❑ Facial Asymmetry
❑ Ear Discharge	❑ Rectal Pain	❑ Headaches
❑ Ear Pain	❑ Vomiting	❑ Light-headedness
❑ Facial Swelling	**ENDOCRINE**	❑ Numbness
❑ Hearing Loss	❑ Cold Intolerance	❑ Seizures
❑ Mouth Sores	❑ Heat Intolerance	❑ Speech Difficulty
❑ Nosebleeds	❑ Polydipsia	❑ Syncope
❑ Postnasal Drip	❑ Polyphagia	❑ Tremors
❑ Rhinorrhea	❑ Polyuria	❑ Weakness
❑ Sinus Pressure	**GENITOURINARY**	**HEMATOLOGIC**
❑ Sneezing	❑ Difficulty Urinating	❑ Adenopathy
❑ Sore Throat	❑ Dysuria	❑ Bruises/Bleeds Easily
❑ Tinnitus	❑ Enuresis	**PSYCHIATRIC**
❑ Trouble Swallowing	❑ Flank Pain	❑ Agitation
❑ Voice Change	❑ Frequency	❑ Behavior Problem
EYES	❑ Genital Sore	❑ Confusion
❑ Eye Discharge	❑ Hematuria	❑ Decreased Concentration
❑ Eye Itiching	❑ Penile Discharge	❑ Dysphoric Mood
❑ Eye Pain	❑ Penile Pain	❑ Hallucinations
❑ Eye Redness	❑ Penile Swelling	❑ Hyperactive
❑ Photophobia	❑ Scrotal Swelling	❑ Nervous/Anxious
❑ Visual Disturbance	❑ Testicular Pain	❑ Self-injury
RESPIRATORY	❑ Urgency	❑ Sleep Disturbance
❑ Apnea	❑ Urine Decreased	❑ Suicidal Ideas
❑ Chest Tightness	**MUSCULAR**	
❑ Choking	❑ Arthralgias	
❑ Cough	❑ Back pain	
❑ Shortness of Breath	❑ Gait Problems	
❑ Stridor	❑ Joint Swelling	
❑ Wheezing	❑ Myalgias	
	❑ Neck Pain	
	❑ Neck Stiffness	

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