PATIENT HISTORY **PRIMARY CARE**

Patient Name: ____________________________________ **Date:** ____

SIGNIFICANT PAST ILLNESSES **APPROX. DATE(S)**

___Abnormal Cholesterol _______________
___Acne _______________
___Arthritis _______________
___Asthma _______________
___Bladder Infection _______________
___Blood Disorders _______________
___Bursitis _______________
___Cancer _______________
___Colitis _______________
___Depression _______________
___Diabetes _______________
___Difficulty Sleeping _______________
___Emphysema/COPD _______________
___Excessive Worry/Anxiety _______________
___Fainting _______________
___Ankle Swelling _______________
___Gall Bladder Disease _______________
___Goiter _______________
___Hat Fever/ Allergic Rhinitis _______________
___Hearing Loss _______________
___Heart Failure _______________
___Heartburn _______________
___Hemorrhoids _______________
___Hepatitis _______________
___High Blood Pressure _______________
___Hypoglycemia _______________
___Infertility _______________
___Irregular Heart Beats _______________
___Kidney Disease _______________
___Liver Disease _______________
___Nervous Stomach _______________
___Nose Bleeds _______________
___Panic Attacks _______________
___Phlebitis/Blood Clots _______________
___Pleurisy _______________
___Pneumonia _______________
___Polio _______________
___Seizure _______________
___Sexual Problems _______________
___Sexually Transmitted Diseases _______________
___Skin Cancer _______________
___Stroke _______________
___Thyroid Disease _______________
___Tuberculosis _______________
___Ulcers _______________
___Visual Problems _______________

Colonoscopy_______________ Mammogram____________________

Pap_________ Bone Density___________ Stress Test____________

HOSPITALIZATIONS **APPROX. DATE(S)**

Reason: ____
____

PAST SURGICAL HISTORY **APPROX. DATE(S)**

____
____
____
____
____

FAMILY HISTORY (cancer, heart disease, diabetes, etc.)

Father:____
____
Mother:____
____
Siblings:____
____
Other:____
____
____

SOCIAL HISTORY

Tobacco Use? ____yes ____no
Type: _______________________________
Frequency: __________________________
Alcohol use? ____yes ____no
How much? _____________
Regular Exercise? ____yes ____no
Sexually active? ____yes ____no
Recreational drug use ____current ____past

____Single ____Married ____Divorced
____Widowed ____Significant Other
____Same Sex Partner

Occupation/Former Occupation: _________________________
____
Number of children: ___________________________________
Hobbies/Interests: ____________________________________
____

FEMALE

Number of pregnancies: _________________________________
Birth Control method: __________________________________
History: ____
Sexually transmitted disease: ___________________________

____

PATIENT SIGNATURE: **DATE:**

REVIEW OF SYSTEMS PRIMARY CARE

Patient Name:______________________________________ **Date:**_____________________________________

Constitution:

___Activity change
___Appetite Change
___Chills
___Excessive Sweating
___Fatigue
___Fever
___Weight Change

Head/Ears/Nose/Throat:

___Congestion
___Dental issues
___Ear discharge/Pain
___Facial swelling
___Hearing loss
___Mouth sores
___Nosebleeds
___Postnasal drip
___Runny nose
___Sinus pain/pressure
___Sneezing
___Sore throat
___Tinnitus (Ringing in the ears)
___Trouble swallowing
___Voice changes

Eyes:

___Eye Discharge/itching/pain
___Eye Redness
___Sensitivity to light
___Visual disturbance

Respiratory:

___Apnea (stop breathing at night)
___Cough
___Chest Tightness
___Choking
___**Short of Breath**
___Wheezing

Cardiovascular:

___Chest Pain
___Leg swelling
___Palpitations (irregular pulse)

Additional Systems Not Found:

Gastrointestinal (GI)

___Abdominal distension
___Abdominal Pain
___Anal bleeding/blood in stool
___Constipation
___Diarrhea
___Nausea
___Rectal Pain
___Vomiting

Endocrine:

___Cold intolerance
___Heat intolerance
___Polydipsia (Excessive Thirst)
___Polyphagia (Excessive Hunger)
___Polyuria (Excessive urination)

Genitourinary (GU)

___Difficult/Painful Urination
___Enuresis (Bedwetting)
___Flank Pain
___Frequency
___Genital sore
___Hematuria (blood in urine)
___Urgency
___Decreased Urine

Male GU

___Penile Discharge/Pain
___Penile or scrotal swelling
___Testicular Pain

Female GU

___Dyspareunia
___Menstrual Problem
___Vaginal bleeding/pain/discharge

Musculoskeletal:

___Arthralgias (Joint Pain)
___Back Pain
___Gait problem
___Joint swelling
___Myalgias (Muscle pains)
___Neck Pain/stiffness

Skin:

___Color Change
___Pallor
___Rash
___Wound

Allergy/Immune System

___Environmental allergies
___Food allergies
___Immunocompromised

Neurological:

___Dizziness/Lightheadness
___Facial Asymmetry
___Headaches
___Numbness
___Seizures
___Speech difficulty
___Syncope (Fainting)
___Tremors
___Weakness

Hematologic:

___Adenopathy (swollen lymph nodes)
___Bruises/bleeds easily

Psychiatric:

___Agitation
___Behavior problems
___Confusion
___Decreased concentration
___Depression
___Hallucinations
___Hyperactive
___Nervous/anxious
___Sleep disturbance
___Suicidal ideas

Enter Patient Name/DOB

Pioneer Family Medicine PLLC

CURRENT MEDICATION LIST:

MEDICATION NAME:	DOSE:	DIRECTIONS	MISC

ALLERGY LIST: