PRIMARY CARE INSTITUTE

Personal Details

Name: ____ Title: Mr / Mrs / Ms / Miss / Dr
Preferred name: ____ Date of birth ____/____/____
Address: ____ Zip Code:_________________
Email address: ____
Phone: Home ____________________ Cell ____________________ Work ____________________

What is the purpose of your visit today? ____
What made you choose our practice? ____

Medical History: Please indicate if you have ever had any of the following:

	Yes	No		Yes	No
Diabetes			Seizures		
High blood pressure			Arthritis		
High cholesterol			Osteoporosis		
Heart problems or pacemaker			Mental illness		
Asthma, emphysema or COPD			Kidney disease		
Cancer (type?)			Hepatitis / Liver problems		
Stroke			HIV / AIDS		

Other, including surgeries or hospitalizations (date and reason): ________________________________
____
____

If you have ever had a colonoscopy, date and result: ____

Female history:
1st Day of Last Period: ____________________
Date of last Pap Smear: ____________________ Normal or abnormal (circle one)
Date of last Mammogram: __________________ Normal or abnormal (circle one)
Number of Pregnancies ______ Children ______ Abortions or miscarriages ______

Medications: (including injections, herbs, supplements and over the counter)

Name	Dose	How often

Name: ___________________________________

Allergies: to medications, foods, insects or latex: (list name and type of reaction): _________________
____

Family History: Please indicate who in your family has any of the following:

Diabetes	
High blood pressure	
High cholesterol	
Cancer (type?)	
Heart disease (age if heart attack)	
Stroke (age?)	
Bleeding disorder	
Alcoholism	
Mental illness	
Osteoporosis	
Other (specify)	

Social History:

Who lives with you? ____
Please circle one: Student Working Retired Unemployed Disabled (why?)
Place and type of work: ____
Do you smoke? _____ Past smoker?_____ #Cig/day _____ #Years _____ Quit date ________________
How much do you drink and how often? ____
Do you use any illegal drugs? (please list) ____

Symptoms: Are you currently having any of the following problems?

	Yes	No		Yes	No
Eye pain / vision problems			Blood in stool / black stools		
Ear pain / hearing problems			Pain with urination		
Throat pain / difficulty swallowing			Blood in urine		
Headaches			Difficulty urinating / leaking		
Chest pain / pressure			Pain in back, joints or muscles		
Heart palpitations / irregular pulse			Skin rashes or changing moles		
Coughing / Wheezing			Sleep problems		
Breathing problems			Sexual problems		
Reflux / heartburn			Depression / anxiety		
Stomach pain			Numbness		
Nausea / vomiting			Confusion		
Diarrhea / constipation			Varicose veins / leg swelling		

Other: Please list other issues or concerns not addressed above:
____
____