PRIMARY CARE ASSOCIATES
QUALITY AND COMPASSIONATE CARE

Health History

PATIENT NAME _____ **DATE OF BIRTH:** _____

DRUG ALLERGIES *(Please list drug name and reaction)*

_____

_____

_____

CURRENT MEDICATIONS (Including any over the counter medications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY (Please check all that apply)

- ○ **Anxiety Disorder**
- ○ **Arthritis**
- ○ **Asthma**
- ○ **Bleeding Disorder**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Has Pacemaker**
- ○ **Heart Attack**
- ○ **Heart Murmur**
- ○ **Hiatal Hernia or Reflux**
- ○ **HIV/AIDS**
- ○ **High Cholesterol**
- ○ **High Blood Pressure**
- ○ **Thyroid Problems**
- ○ **Kidney Disease**
- ○ **Kidney Stones**
- ○ **Leg/Foot Ulcers**
- ○ **Liver Disease**
- ○ **Osteoporosis**
- ○ **Pulmonary Embolism**
- ○ **Reflux or Ulcers**
- ○ **Stroke**
- ○ **Tuberculosis**
- ○ **OTHER**

CIRCLE OF CARE I am currently seeing the following specialist(s)

- ○ **Allergist**
- ○ **Behavioral Health**
- ○ **Cardiology**
- ○ **Dermatology**
- ○ **Endocrinology**
- ○ **Ear, Nose, Throat**
- ○ **Gastroenterology**
- ○ **GYN/OBGYN**
- ○ **Hematology/Oncology**
- ○ **Infectious Disease**
- ○ **Nephrology**
- ○ **Neurology**
- ○ **Orthopedic**
- ○ **Pain Management**
- ○ **Physical Therapy**
- ○ **Podiatry**
- ○ **Pulmonology**
- ○ **Rheumatology**
- ○ **Urology**
- ○ **OTHER**

PREVENTATIVE HEALTH Dates of last exam/immunizations

Bone Density	_____	**Mammogram**	_____	**Shingles**	_____
Colonoscopy	_____	**Pap Smear**	_____	**Tetanus**	_____
Dental Exam	_____	**Pneumococcal**	_____		
Eye Exam	_____	**Influenza**	_____		

PATIENT NAME _____ **DATE OF BIRTH:** _____

SURGICAL HISTORY

Procedure:	**Year performed:**

FAMILY HISTORY

Please list any known conditions for each family member:

Mother	Father	Grandmother	Grandfather

SOCIAL HISTORY

Current Occupation: _____ ○ **Retired**

Number of Children: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Exercise: ○ Daily ○ _____days/week ○ Rarely ○ Never

Type of Exercise: _____

How often do you consume alcohol?

○ Daily ○ _____days/week ○ Rarely ○ Socially ○ Never

Type of alcohol typically consumed? _____

How often do you consume caffeine?

○ Daily ○ _____days/week ○ Rarely ○ Socially ○ Never

Type of Caffeine typically consumed? _____

Are you now or have you ever been a smoker?

○ **Yes** Currently, _____/daily
○ **No** Quit Date: _____
○ **Never**