Primary Physician Partners, P.C.
Partners in Internal Medicine, P.C.
Health History and Screening Form

Name: _____ DOB:_____

Medication:

Name	Dose	Frequency

Medical History(i.e. serious childhood illness, chicken pox, high blood pressure, diabetes, cancer, sexually transmitted infections, heart disease etc.):

Please describe condition:	When?

Allergies (please list allergies):

Gyn. History:

Date of last period	
Date of last pap smear	
Date of last mammogram	
Method of pregnancy prevention	
Total pregnancies	

Surgery:	Year:

Hospitalizations:

Reason:	Year:

Family History:

Family Member	Medical problem

Social History:

Do you smoke? If yes, how much?	
When was your last cholesterol check? (date/result)	/
Do you use a seat belt?	
Do you have a gun in the house?	
Do you drink alcohol? If yes, how often?	
What is your marital status?	
Do you have children? If yes, how many?	
What is your occupation?	
Do you exercise regularly?	
What is your daily caffeine intake?	
Are you sexually active?	
Do you travel outside the U.S. often?	
Do you have a smoke detector in your home?	
Do you have pets?	

Recent conditions:
In the past 6 months, circle if you have had trouble with the following:

Allergy symptoms
Weight loss
Weight gain
Fatigue
Chest pain
Shortness of breath
Palpitations
Dizziness
Leg swelling
Vaginal discharge
Hot flashes
Change in periods

Abdominal pain
Heartburn
Change in bowels
Blood in stool
Joint pain
Headache
Visual change
Sleep problems
Depression
Anxiety
Cough
Urinary problems