**TODAY's Date**_____________________

# Valley Primary Care Patient History Form

*Note: To better meet and maintain your medical needs this form is required by your physician to be updated on an annual basis, REGARDLESS IF CHANGES HAVE OCCURRED.*

**Patient Name:**_______________________________________________**D.O.B:**__________________

**Social security #:** ___________________________*(at least last 4digits)*

## Family Medical History

Please check all that apply. Have **YOU** or **ANYONE** in your family had any of the following illnesses:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | HEART DISEASE, STROKE, OR HEART ATTACK | SELF | MOTHER | FATHER | SISTER | BROTHER | GRANPARENT | UNCLE | AUNT |
| 2. | HIGH BLOOD PRESSURE | SELF | MOTHER | FATHER | SISTER | BROTHER | GRANPARENT | UNCLE | AUNT |
| 3. | DIABETES | SELF | MOTHER | FATHER | SISTER | BROTHER | GRANPARENT | UNCLE | AUNT |
| 4. | COLON CANCER | SELF | MOTHER | FATHER | SISTER | BROTHER | GRANPARENT | UNCLE | AUNT |
| 5. | BREAST CANCER | SELF | MOTHER | FATHER | SISTER | BROTHER | GRANPARENT | UNCLE | AUNT |

## Medical History

Do you have any other medical problems?______________________________________________

_____________________________________________________________________________

Are you allergic to any medication? Please list:_________________________________________

_____________________________________________________________________________

Do you have a Living Will or Advance directive? Yes No

Date of last tetanus shot?____________________________ Other Vaccinations?___________________

Please circle all that apply. Have you had any of the following surgeries?

GALLBLADDER HYSTERECTOMY KNEE/HIP REPLACEMENT HEART SURGERY C-SECTIONS

LIST ANY OTHER SURGERIES:_________________________________________________________

_____________________________________________________________________________

LIST ANY HOSPITALIZATIONS:________________________________________________________

Do you smoke? YES NO How much?__________________ How long?_____________________

Do you drink alcohol? YES NO How much?__________________ Do you use street drugs? YES NO

Have you ever had a blood transfusion or Plasma? YES NO What year?______________________

FOR WOMEN ONLY: 1st day of last menstrual period_________________ # of pregnancies___________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENLTY TAKING:

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

## PLEASE COMPLETE REVERSE SIDE

**(over)**

Do you **CONSTANTLY** have any of the following problems related to the following systems?
Please answer **all** of the questions either yes or no.

**Constitutional**

| | | |
|---|---|---|
| Fever | YES | NO |
| Chills | YES | NO |
| Weight Loss | YES | NO |
| Weight Gain | YES | NO |

Other_____________________

**Eyes**

| | | |
|---|---|---|
| Blurred Vision | YES | NO |
| Double Vision | YES | NO |
| Pain | YES | NO |

Other_____________________

**Allergic/Immunologic**

| | | |
|---|---|---|
| Runny Nose | YES | NO |

Other_____________________

**Neurologic**

| | | |
|---|---|---|
| Tremors | YES | NO |
| Headaches | YES | NO |
| Numbness | YES | NO |
| Tingling | YES | NO |

**Endocrine**

| | | |
|---|---|---|
| Excessive Thirst | YES | NO |
| Too Hot/Cold | YES | NO |
| Tired/Sluggish | YES | NO |

Other_____________________

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal Pain | YES | NO |
| Nausea/Vomiting | YES | NO |
| Diarrhea | YES | NO |
| Constipation | YES | NO |
| Indigestion | YES | NO |
| Heartburn | YES | NO |

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | YES | NO |
| Varicose Veins | YES | NO |

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | YES | NO |
| Boils | YES | NO |
| Persistent Itch | YES | NO |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | YES | NO |
| Neck Pain | YES | NO |
| Back Pain | YES | NO |

Other:_________________________

**EAR/NOSE/THROAT/MOUTH**

| | | |
|---|---|---|
| Ear Infection | YES | NO |

**Genitourinary**

| | | |
|---|---|---|
| Painful Urination | YES | NO |
| Frequent Urination | YES | NO |
| Urine Loss While Coughing/Sneezing | YES | NO |
| Problems with sex | YES | NO |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | YES | NO |
| Frequent Cough | YES | NO |
| Shortness of Breath | YES | NO |

**Hematologic**

| | | |
|---|---|---|
| Swollen Glands | YES | NO |
| Blood Clotting | YES | NO |

**Psychological**

| | | |
|---|---|---|
| Are you generally satisfied with your life? | YES | NO |
| Do you feel depressed? | YES | NO |
| Difficulty Sleeping? | YES | NO |

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***FOR OFFICE STAFF ONLY:***

_______________________________________ _______________

*PHYSICIAN SIGNATURE* *DATE*