CENTER FOR PRIMARY CARE

PATIENT HEALTH HISTORY
(Confidential)
If completing form by hand, please print

CPC- _____
(office location)

Name_____ Today's Date_____

☐ Male ☐ Female Age_____ Birthdate_____ Date of last physical examination_____
mm / dd / yyyy

Marital status_____ Occupation_____

What is the reason for your visit today?_____

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
_____Menstrual period	_____Cholesterol testing	_____Pneumonia vaccine	_____Digital rectal exam
_____Mammogram	_____Colonoscopy	_____Bone Density (DEXA)	_____PSA (prostate blood test)
_____Pap smear	_____Tetanus booster		

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type _____	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema/COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections

☐ Other _____

ALLERGIES? *Check ☑ appropriate box below. If yes, please list all known allergies to medications or substances*

☐ No known allergies ☐ Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check ☑ appropriate boxes below and describe*

Caffeine	☐ None	☐ _____ drinks per _____	
Tobacco	☐ None	☐ _____ cigarettes per day	☐ Quit smoking around _____
Alcohol	☐ None	☐ _____ drinks per _____	
Drugs	☐ None	☐	
Diet	Describe:		
Exercise	Describe:		
Seat belts	☐ Always	☐ Never	☐ Sometimes

(Continued on back)

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications, if any

PREGNANCY HISTORY

pregnancies_____ ; # living children _____

deliveries: C-sections_____ ; vaginal _____

Birth year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

Have you ever had a blood transfusion? ☐ No ☐ Yes Date(s):

FAMILY HISTORY

Fill in information about your family below:

Check ☑ if a blood relative has had any of the following:

Relation	Age, if living	Age at death	Medical conditions / cause of death	Disease	Relationship to you
Father				☐ Arthritis	
Mother				☐ Asthma	
Brothers				☐ Cancer	
				☐ Diabetes	
				☐ Gout	
				☐ Heart disease	
Sisters				☐ High blood pressure	
				☐ Kidney disease	
				☐ Stroke	
				☐ Other	

ADDITIONAL INFORMATION

What else do you think your doctor should know about your health?

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ Reviewed by_____ Date_____