Primary Care Self-Administered History Form

Patient Legal Name: _____ Date of Birth: _____ Today's Date: _____

Preferred Name: (if different than above) _____ Please indicate your highest level of education: _____

Current Job: _____ Previous Jobs: _____

Who lives with you? (Family, Boarders, Friends) _____

Family/Health History:

			Health Problems (Check all that apply) **Provide any additional siblings, children or other information below*															
History	Living (Y/N)	Age	High Cholesterol	Osteoporosis	Heart Trouble	Cancer (List Type)	Diabetes	High Blood Pressure	Mental Illness	Thyroid Disease	Bleeding Trouble or Blood Clots	Glaucoma	Alcohol/Drug Problem	Dementia	Stroke	Asthma/COPD	Rheumatological Conditions/Lupus	Other (List Below)
Self																		
Mother																		
Father																		
Sister																		
Brother																		
Child																		
Maternal Grandmother																		
Paternal Grandmother																		
Maternal Grandfather																		
Paternal Grandfather																		
Other																		

***Additional Information:** _____

_____

Medication: List any medications you take (include over-the-counter)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Patient Legal Name: _____ Date of Birth: _____

List Allergies or Bad Reactions to Medicines:

_____

_____

Immunizations and Tests: Check the box next to those you have received the test/vaccination, and indicate the year in the line provided.

Vaccinations

□ _____ Flu Shot	□ _____ Zostavax	□ _____ Cholesterol	□ _____ Dental Care
□ _____ Prevnar/Pneumovax	□ _____ Tdap	□ _____ Stool Test for Blood	□ _____ Hep C
□ _____ Tetanus Shot	□ _____ Chicken Pox Vaccine	□ _____ Colonoscopy	□ _____ HIV
□ _____ Polio Series	□ _____ Meningococcus	□ _____ Mammogram	□ _____ Prostrate Screening
□ _____ MMR (Measles, Mumps, Rubella)	□ _____ Gardasil	□ _____ Pap Smear	
	□ _____ Hepatitis B	□ _____ Dexa Scan	□ _____ Other _____
□ _____ Shingrix	□ _____ Hepatitis A	□ _____ Tuberculosis Test	□ _____ Other _____

Other Health Issues: (Complete or Discuss with your Doctor)

Smoking Tobacco Use: Never Used □ Former User □ Type: Cigarettes □ Pipe □ Cigars □

Smokeless Tobacco Use: Never Used □ Former User □ Type: Snuff □ Chew □ Vaping □

When did you start? _____ How much per day? _____

Alcohol: ..... Yes □ No □

How many drinks per week? _____ During the last month, most drinks in one day? _____

Do you use recreational drugs? ..... Yes □ No □

If yes, what substance? _____

Do you exercise regularly? ..... Yes □ No □

Do you have concerns about HIV or AIDS? ..... Yes □ No □

Do you use seat belts regularly? ..... Yes □ No □

Do you have smoke detectors in your home? ..... Yes □ No □

Do you keep loaded fire arms in your home? ..... Yes □ No □

Do you have a written Advance Directive or Living Will? ..... Yes □ No □

Who do you want to make decisions for you if you can't speak for yourself? _____

Do you feel emotionally and physically safe with the person/partner you are with? ..... Yes □ No □

Are you sexually active? ..... Yes □ No □

Do you practice and understand safe sex? ..... Yes □ No □

Do you partner with men, women or both? _____

What type of birth control/protection do you use? _____

Hospitalizations/Procedures:

Year	Operation or Hospitalization	Year	Operation or Hospitalization

What sex were you assigned at birth? _____ What is your gender? _____

Gynecologic and Obstetric History: (if applicable)

Age at first period: _____ Frequency: _____ Length of Periods: _____

Menopause Age: _____ Hysterectomy: □ Yes □ No Hormone Replacement Therapy: □ Yes □ No

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Decrease in Height: ☐ Yes ☐ No If yes, number of inches: _____

Number of Pregnancies: _____ Number of Births: _____ Number of Miscarriages: _____

Number of Living Children: _____ Complications with prior pregnancies: _____ Diabetes during pregnancy: ☐ Yes ☐ No

Please place a check beside any of the problems that you are experiencing now or within the past month. If you are not experiencing issues in any category, please check here: ☐

Constitution
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Malaise/Fatigue
- ☐ Heavy sweats
- ☐ Weakness

Skin
- ☐ Rash
- ☐ Itching
- ☐ Change in moles
- ☐ Lumps
- ☐ Nail changes
- ☐ Skin wounds

Head Ears Nose Throat
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Mouth ulcers/sores
- ☐ Taste disturbances
- ☐ Head/Chest congestion
- ☐ Hoarseness
- ☐ Dental/Gum disease
- ☐ Difficulty swallowing

Eyes
- ☐ Blurred Vision
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness
- ☐ Vision changes

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg swelling

Respiratory
- ☐ Cough
- ☐ Coughing blood
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Snoring

Psychiatric
- ☐ Depression
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Sleep problems
- ☐ Eating disorder
- ☐ Mood swings
- ☐ Difficulty concentrating
- ☐ Panic attacks
- ☐ Irritable

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Change in appetite
- ☐ Change in stool color
- ☐ Stool incontinence
- ☐ Bloating

Genitourinary
- ☐ Burning urination
- ☐ Urgency
- ☐ Frequency
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Change in urination
- ☐ Frequent urination at night
- ☐ Urine leakage
- ☐ Irregular periods
- ☐ Vaginal bleeding
- ☐ Pelvic pain
- ☐ Sexual problems
- ☐ Vaginal discharge

Endocrine
- ☐ Easy bruise/bleeding
- ☐ Hair changes
- ☐ Excessive hunger
- ☐ Excessive thirst

Hematology
- ☐ Enlarged/Swollen glands

Allergies
- ☐ Environmental allergies

Neurological
- ☐ Dizziness/Lightheadedness
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Fainting/Passing out
- ☐ Balance problems
- ☐ Confusion
- ☐ Memory loss

Musculoskeletal
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls
- ☐ Decreased range of motion
- ☐ Unsteady gait

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____