

PRIMARY CARE

of M I L T O N

Greenway ID # _____

Date: _____

Patient Name: _____

Date of Birth ___ / ___ / ___

REASON FOR VISIT:

MEDICATIONS SUPPLEMENTS AND VITAMINS: (Please list the name, dosage and frequency of current medications)

	MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Patient brought in Medication List

Medication List Reviewed by MA

Allergies: _____

Patient Name: _____

Date of Birth ___ / ___ / ___

PAST MEDICAL HISTORY: (Please check box and put date diagnosed)

- High Blood Pressure _____
- High Cholesterol _____
- Diabetes _____
- Stroke _____
- Anxiety _____
- Other: _____
- Arthritis _____
- Kidney Disease _____
- Asthmas _____
- Osteoporosis _____
- Depression _____
- Thyroid Disease (please specify) _____
- Heart Disease (please specify) _____
- Cancer (please specify) _____
- Clotting disorder (please specify) _____
- Acid Reflux _____

PAST SURGICAL HISTORY (Please list any surgical procedures, hospitalizations and their dates)

NAME	DATE

SOCIAL HISTORY

Do you currently smoke or chew tobacco? Yes No
 If yes, how long have you smoked? _____
 How much do you smoke per day? _____
 If you smoked previously, how long did you smoke, how much per day and when did you quit? _____

Do you currently drink alcohol? Yes No
 How much do you drink? _____
 Do you feel like you need to cut back? _____

Do you exercise regularly? Yes No If yes, how often and for how long do you exercise? _____
 Have you used illicit drugs? Yes No If yes, what have you used? _____
 Do you desire STD Screening? Yes No

FAMILY HISTORY (Please list below blood relatives that have a history of the following:)

(<input checked="" type="checkbox"/> boxes that apply)	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Other (Please list)
Mother										
Father										
Siblings										
Grandmothers										
Grandfathers										
Aunts										
Uncles										
1st Cousins										
Children										

Patient Name: _____

Date of Birth ___ / ___ / ___

PLEASE FILL IN DATE OF YOUR LAST:

Colonoscopy		Pap Smear		Shingles shot	
Mammogram		Flu shot (Regular/High Dose)		Pneumonia shot (Pneumovax 23)	
Bone Density		Tetanus shot		Pneumonia shot (Pneumar 13)	
First day of last menstrual cycle:					

REVIEW OF SYSTEMS (Please verify if you have had any of the following within the last 30 days)

Please circle all that apply and explain

CONSTITUTIONAL

Fever YES NO _____
 Weight Loss YES NO _____
 Difficulty Sleeping YES NO _____
 Fatigue YES NO _____
 Weight Gain YES NO _____
 Dehydration YES NO _____
 Headache YES NO _____

Heartburn YES NO _____
 Diarrhea/Loose Stools YES NO _____
 Mucus in Stool YES NO _____
 Loss of Appetite YES NO _____
 Bloating YES NO _____
 Constipation YES NO _____
 Excessive Belching YES NO _____
 Changes in Bowel Habits YES NO _____

EYES

Changes in Vision YES NO _____
 Far-Sightedness YES NO _____
 Near-Sightedness YES NO _____
 Total Vision Loss YES NO _____
 Eye Pain YES NO _____

GENITOURINARY

Difficulty Urinating YES NO _____
 Sexually Transmitted Infections YES NO _____
 Incontinence YES NO _____
 Kidney Trouble YES NO _____
 Irregular Periods YES NO _____
 Erectile Dysfunction YES NO _____

EARS, NOSE, MOUTH, AND THROAT

Loss of Hearing YES NO _____
 Cold Symptoms YES NO _____
 Ringing in Ears YES NO _____
 Hoarseness YES NO _____
 Sneezing Spells YES NO _____
 X-Ray Exposure to Tonsils, Adenoids, Thymus, or Face YES NO _____

NEUROLOGIC

Dizziness YES NO _____
 Fainting YES NO _____
 Muscular Weakness YES NO _____
 Tingling or Numbness YES NO _____
 Seizures YES NO _____
 Nervous Disorders YES NO _____

BREASTS

Lumps YES NO _____
 Nipple Discharge YES NO _____
 Tenderness YES NO _____
 Abnormal Changes in Breast Size YES NO _____

MUSCULOSKELETAL

Joint Pain YES NO _____
 Joint Swelling YES NO _____
 Reddish Coloring at Joints YES NO _____
 Stiffness YES NO _____
 Muscle Pain YES NO _____
 Muscular Weakness YES NO _____
 Back Pain YES NO _____
 Arm Pain YES NO _____
 Leg Pain YES NO _____
 Leg Cramps YES NO _____
 Urge to Move Legs YES NO _____

RESPIRATORY

Wheezing YES NO _____
 Dry Cough YES NO _____
 Shortness of Breath YES NO _____
 Productive Cough YES NO _____

ENDOCRINE

Thyroid Disease YES NO _____
 Diabetes Mellitus YES NO _____

CARDIOVASCULAR

High Blood Pressure YES NO _____
 Heart Trouble YES NO _____
 Palpitations YES NO _____
 Edema (swelling) YES NO _____
 Chest Pain YES NO _____

PSYCHIATRIC

Depressive Symptoms YES NO _____
 Anxiety YES NO _____
 Psychosis YES NO _____
 Hallucinations YES NO _____

GASTRONINTESTINAL

Abdominal Pain YES NO _____
 Vomiting YES NO _____
 Nausea YES NO _____
 Blood in Stool YES NO _____
 Tarry or Black Stool YES NO _____
 Hemorrhoids YES NO _____
 Hernias YES NO _____

ALLERGIC-IMMUNOLOGIC

Sinus Allergy Symptoms YES NO _____
 Allergic Dermatitis YES NO _____

Patient's Signature: _____

Date: _____