Memorial PRIMARY CARE | URBANA

PATIENT HISTORY

PATIENT NAME (Last, First, MI.)	BIRTH DATE	AGE	SEX Male Female	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY/STATE		ZIP CODE	PHONE (Home) PHONE (Work)

LAST TETANUS DATE:	MEDICATIONS		SURGERY
ALLERGIES and REACTION			

PERSONAL HISTORY: Have you EVER had any of the following medical conditions, (circle)?

- ❑ Anemia/ Bleeding Disorder
- ❑ Blindness/Vision Loss
- ❑ Color Blindness
- ❑ Deafness/Hearing Loss
- ❑ Sinus Problems/Hay Fever
- ❑ Diabetes/Sugar Disorder
- ❑ Thyroid Disease/Goiter
- ❑ Abnormal Mammogram
- ❑ Asthma
- ❑ Emphysema/Bronchitis
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Silicosis
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Rheumatic Fever
- ❑ Heart Murmur
- ❑ Abnormal Valve
- ❑ Gallstones
- ❑ Stomach Ulcers
- ❑ Hepatitis/Jaundice
- ❑ Bowel Disease
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Severe Bladder Infections
- ❑ Sexually Transmitted Disease
- ❑ Abnormal Pap Smear
- ❑ Back or Neck Pain
- ❑ Knee or Hip Pain
- ❑ Broken Bones
- ❑ Rheumatoid Arthritis
- ❑ Stroke/Paralysis
- ❑ Seizures/Convulsions
- ❑ Severe Headaches
- ❑ Depression
- ❑ Emotion Problems
- ❑ Alcohol/Drug Abuse
- ❑ Cancer/Tumor

PERSONAL HISTORY: THIS PAST YEAR have you had the following, (Circle)?

- ❑ Skin Problems
- ❑ Hoarseness of Voice
- ❑ Difficulty Swallowing
- ❑ Chronic Cough
- ❑ Shortness of Breath
- ❑ Chest Pain or Aching
- ❑ Irregular Heart Beats
- ❑ Leg Cramps
- ❑ Swollen Ankles
- ❑ Chronic Indigestion
- ❑ Persistent Diarrhea
- ❑ Bloody Stool
- ❑ Breast Lump or Mass
- ❑ Abnormal Vaginal Bleeding
- ❑ Routine Pap Smear
- ❑ Memory Loss
- ❑ Weakness in Arm or Leg
- ❑ Tremor
- ❑ Frequent or Severe Headache
- ❑ Hand or Wrist Pain
- ❑ Anxiety or Depression
- ❑ Hospitalization
- ❑ Surgery

Family History:

- ☐ Diabetes
- ☐ Heart Attack < 50
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Alcoholism
- ☐ Allergies

Gynecological History:
(Your physician will complete)

Gravida: Para:

FDLMP:

Mammography:

SOCIAL HISTORY: Single / Married / Divorced / Widowed

Do you smoke? ❑ yes ❑ no

If "yes," how many packs/day? _____

Also, how many years? _______

If 'no," have you smoked in the past? yes no

How many drinks to you have per day or week?______ (beer, wine, or liquor)

____

How many caffeine drinks do you have each day?____

Do you wear a seatbelt regularly? yes no

Where do you work? ____

How many days per week do you exercise? _____

How many minutes per session do you exercise?_____

What type of exercise?

____

What hobbies do you have?

____

What Pets do you have?

____