pcim
Primecare Internal Medicine

SPECIALIZING IN DIABETES AND HYPERTENSION
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History & Physical

DATE:

NAME | DATE OF BIRTH

ADDRESS | PHOHE (H) (O)

OCCUPATION/EMPLOYER | INSURANCE

Family History

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1. Epilepsy	6. Hay Fever	11. Arthritis	16. Hepatitis _____
2. Migraine	7. Asthma	12. Heart Disease	17. Cancer _____
3. Glaucoma	8. Anemia	13. Stroke	18. Depression _____
4. Diabetes	9. Bleeding Disorder	14. Hypertension	19. Alcoholism _____
5. Thyroid Disease	10. Osteoporosis	15. Lipid Disorder	20. Mental Illness _____

Hospital Admissions

(Not Including Pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

SUPPLEMENTS

VACCINE *YEAR OF LAST*	VACCINE *YEAR OF LAST*
Telanus/Td _____	**Tdap** Telanus Diptheria _____ Whooping C
Influenza (flu) _____	**MMR** Red Measles Mumps _____ Measles
Pneumonia _____	**Meningitis** _____
Hepatitis B _____	**Chicken Pox** _____
Hepatitis C _____	
Whooping C _____	

Medical History

MARK (C) FOR CURRENT PROBLEM. CHECK ( ) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES

MAIN PROBLEM _____

* Hearing Problems
* Dizzy Spells
* Vision Problems * Eye Pain
  Date of last eye exam _____
* Nose Bleeds * Sinus Trouble
* Sore Throats - Frequent
* Hoarseness - Prolonged
* Pneumonia
* Chronic Cough
  Date of last TB test _____
* Shortness of Breath
* Chest Pain * High Blood Pressure
  Date of last cholesterol test _____
* Heart Murmur
* Irregular Pulse
* Leg Pain
* Heartburn
* Aspirin - Arthritis - Pain Pills
* Nausea/Vomiting
* Diarrhea * Constipation
* Diverticulosis
* Bloody or Tarry Stools
* Test for blod in stool
* Hemorrhoids * Hernia
* Urination - Overactive Bladder
  * Overnight > than twice
  * More than 8 times/24hrs
  * Urgency to urinate * with leakage
* Decrease in force/flow * Painful
* Blood in urine * Kidney Stones
* Weight-Loss * Gain
* Anemia * Bruise Easily
* Cancer * Fatigue/Loss of Energy
* Diabetes * Thyroid Disease
* Arthritis/Rheumatism * Back Pain
* Bone Fracture
* Osteoporosis * Gout
* Rashes
* Psoriasis
* Seizures * Stroke
* Depression
* Decreased life enjoyment
* Decreased work performance
* Sleep Problems
  Sleeping - * too little * too much
  * waking refreshed
* Concentration Problems
* Anxiety * Mood Swings
* Mental Illness
* Sexual Problems/Enjoyment
* Smoking - cig/day _____ # years
  year quit _____
* Hair loss: * Progressive * Recent
* Exercise _____
* Street Drugs _____

Females - Please complete
Menstrual flow:
* Reg * Irreg. * Pain/Cramps
Days of flow ____ Length of cycle ____
Date - 1st day of last period _____

* Pain/Bleeding during or after sex
Number of:
Pregnancies ____ Abortions ____
Miscarriages ____ Live births ____
Birth control method _____
Date of last PAP test _____
* Normal * Abnormal
Date of last mammogram
* Normal * Abnormal

Synopsis

_____

_____

_____