

FIRST HEALTH ASSOCIATES – General Medical History Form

Name: _____ Date of Birth: _____ Gender: M F

Primary Care Physician: _____ Phone: _____

PCP Address: _____

We may send a copy of your treatment plan (as well as all reports, exams and labs) to your primary care physician. Please, sign here to indicate that you read and understand our policy regarding this. If you have any questions, please ask.

Patient signature: _____ Date: _____

Past Medical History

Are you currently being treated by another medical professional for any condition – either new problem or chronic problem? No, I only go for checkups Yes, please see below

Condition	Date of onset
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____

Have you, in the past, been treated for anything other than routine, short-lived illnesses (colds, flu, etc)?
No, only for checkups and simple problems Yes, see below

Condition	Date of onset
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____

Have you ever had surgery? Yes, please see below No, never

Condition	Date of surgery (month, year)
• _____	_____
• _____	_____
• _____	_____

Have you ever seen someone for emotional, behavioral or psychological issues (including couples counseling, anger counseling, grief counseling, etc.)? Yes No

Condition	Date
• _____	_____
• _____	_____
• _____	_____

Patient Signature: _____ Date: _____

Review of Systems

Please indicate whether you have ever had the following conditions; if you have, please indicate if it is an active issue or in the past.

General <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Lack of energy <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats <input type="checkbox"/> Sweat easily <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Anemia	Skin <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Eczema <input type="checkbox"/> Pimples <input type="checkbox"/> Dry skin/scalp <input type="checkbox"/> Moles <input type="checkbox"/> Warts <input type="checkbox"/> Changes in skin/hair <input type="checkbox"/> Sores on skin/in mouth	Head, Eyes, Nose Throat <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Poor hearing <input type="checkbox"/> Blurry vision <input type="checkbox"/> Troubled vision (glasses?) <input type="checkbox"/> Eye pain <input type="checkbox"/> Facial pain <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Teeth problems <input type="checkbox"/> Hoarse or altered voice
Cardiovascular <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Abnormal rhythm (atrial fibrillation or flutter, for example) <input type="checkbox"/> Failed stress test <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling in arms or legs <input type="checkbox"/> Bleeding/clotting problems <input type="checkbox"/> Blood clot	Respiratory <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough with sputum <input type="checkbox"/> Dry cough <input type="checkbox"/> Seasonal, environmental allergies <input type="checkbox"/> Snoring	Digestive <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Bloating <input type="checkbox"/> Excessive gas <input type="checkbox"/> Bloody or dark stool <input type="checkbox"/> Pain or cramping <input type="checkbox"/> Gallstones <input type="checkbox"/> Liver problems
Genito-urinary <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urgency with urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decreased urine flow <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Incontinence – ever <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Changes in sex drive <input type="checkbox"/> Frequent nighttime urination	Gynecological <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Heavy periods <input type="checkbox"/> Missed periods <input type="checkbox"/> PMS/PMDD <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge	Obstetrical # of pregnancies: _____ # of births: _____ # of premature births: _____ Age of 1 st menses: _____ # days between menses: _____ 1 st day of last menses: _____ Age of menopause: _____ Date of last PAP: _____ Date of last Mammo: _____
Musculoskeletal <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Elbow, wrist or hand pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle or foot pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Tender joint <input type="checkbox"/> Muscle pain <input type="checkbox"/> Weakness	Neurological <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of strength <input type="checkbox"/> Loss of balance <input type="checkbox"/> Poor memory <input type="checkbox"/> Seizures <input type="checkbox"/> Head injury <input type="checkbox"/> Nerve damage <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Difficulty concentrating	Behavioral <input type="checkbox"/> Mood swings <input type="checkbox"/> Sadness <input type="checkbox"/> Anxiety <input type="checkbox"/> Aggressiveness/anger <input type="checkbox"/> Panic attacks <input type="checkbox"/> Uncontrollable fear <input type="checkbox"/> Substance abuse <input type="checkbox"/> Vacant <input type="checkbox"/> Easily stressed <input type="checkbox"/> Inappropriate thoughts <input type="checkbox"/> Uncontrollable thoughts

Patient Signature: _____ Date : _____

Medications

Do you take any medications (what kind, how much, how often)? _____

- _____

- _____

- _____

Do you have any allergies to medications? _____

Family History

Relation	Age	Age at death	Medical problems
Father			
Mother			
Brothers			
Sisters			
Children			

Social History

What is your occupation? _____

What are your hobbies? _____

Do you exercise (what kind, how often)? _____

Who lives at home with you? _____

What is your marital status? _____

Do you smoke (how much)? _____

Do you drink (how much)? _____

Do you use any illicit drugs (what kind, how often, how much)? _____

Do you consume caffeine (what kind, how much, how often)? _____

Are you satisfied with your weight and fitness? _____

I have read the above and reviewed it with the patient.

Physician Signature _____ **Date:** _____