Primary Care West, P.C.

Annual Medical History Form

Name _____ Medications/Vitamins/Supplements Major Injuries/Surgeries *MM/DD/YYYY*

Date _____ _____ _____

DOB _____ _____ _____

Biological Gender _____ _____ _____

Pronoun _____ _____ _____

Occupation _____ _____ _____

Preferred Pharmacy: _____ _____ _____

Allergies *Reaction* **Allergies** *Reaction*

_____ _____

_____ _____

_____ _____

Optometrist: _____ Dentist: _____ OBGYN: _____

Date Last Seen: _____ Date Last Seen: _____ Date Last Seen: _____

Smoking/Vaping

☐ Current ☐ Past ☐ Never

Cigarettes/e-cigs a day _____

Age Started Smoking _____

Years smoked _____

Interest in quitting? _____

Caffeine: ☐Yes ☐No

Per Day _____

Type _____

Alcohol: ☐Yes ☐No

How many drinks per week?

_____

Type: _____

Exercise: ☐Yes ☐No

Type _____

How often_____

Calcium Intake:

Milk

Cups/day_____

Supplements

Mg/day_____

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly everyday
2. Feeling down, depressed, or hopeless? ☐ Yes ☐ No
3. How many times per year have you used a recreational drug or used a prescription medication for non-medical reasons? ☐ None ☐ 1 or more
4. How many times in the past year have you had 4 or more drinks in a day? ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly everyday

Screening History

Year of last Tetanus_____ Year of last TB test_____ Had a shingles shot? _____

Do you get yearly flu shots? _____ Last pneumonia shot_____

Have you had a mammogram? _____ Have you had a colonoscopy? _____

If so, when was it? _____ If no, have you done a stool occult or cologuard? _____

Family Health Information

	Self	Mother	Father	Siblings	Gparents	Comments
ADD/ADHD						
Anesthetic Reaction						
Asthma						
Autism						
Bleeding/Clotting Disorder						
Cancer *(Specify kind)*						
Depression/Anxiety						
Diabetes						
Early unexplained death						
Elevated Cholesterol						
Heart Attack *(age)*						
Heart Disease						
High Blood Pressure						
Mental Health – Other *(Bipolar, schizophrenia)*						
Migraines						
Scoliosis						
Seasonal Allergies						
Seizure Disorder						
Thyroid Disease						

Gynecology History

Age on onset of your very first period _____ First day of last period_____

Number of days between periods _____ How many days do you flow? _____

On your heaviest days, how many tampons/pads do you use? How many heavy days do you have? _____

Do you have bleeding between periods? _____ Any bleeding after sex? _____

Have you had a hysterectomy? _____ If yes, were your ovaries removed? _____

If menopausal, when was your last period? _____ Do you wish to discuss hormones? _____

Have you ever had an abnormal pap? _____ If yes, when? _____What did it show? _____

Number of pregnancies_____ Number of live births_____ Number of abortions/miscarriages? _____

Have you had more than one partner in your lifetime? _____

Have you had a new partner since your last exam? _____

Do you have need for birth control now? _____ Current method of birth control? _____

Safety and Wellness

Yes	No	
☐	☐	In the past year, have you been afraid of your partner/ex-partner?
☐	☐	Do you feel physically and emotionally unsafe where you currently live?
☐	☐	Has the lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

In the past year, have you or any family member you live with been unable to get any of the following when it was really needed?

☐ Food ☐ Clothing ☐ Utilities ☐ Child Care ☐ Phone ☐ Medicine/Healthcare ☐ Other_____

Current Symptoms and/or Problems

Current	Past	None		Current	Past	None	
☐	☐	☐	Frequent UTIs	☐	☐	☐	Recurrent vaginal warts
☐	☐	☐	Frequent Urination	☐	☐	☐	History of STI
☐	☐	☐	Burning with Urination	☐	☐	☐	Infection of uterus, ovaries, or tubes
☐	☐	☐	Blood in Urine	☐	☐	☐	History of herpes
☐	☐	☐	Lose Urine when you don't want to				
				☐	☐	☐	Frequent bronchitis
☐	☐	☐	Weight gain/loss	☐	☐	☐	Asthma
☐	☐	☐	Prolonged bleeding after cut	☐	☐	☐	TB/TB exposure
☐	☐	☐	Bruise easily				
☐	☐	☐	Heat/cold intolerance	☐	☐	☐	Swelling of hands/feet
☐	☐	☐	Unusual hair growth/loss	☐	☐	☐	Irregular heartbeat/palpitations
☐	☐	☐	Worrisome moles	☐	☐	☐	Frequent Heartburn
				☐	☐	☐	Food Intolerance
☐	☐	☐	Frequent severe headaches				
☐	☐	☐	Blackouts	☐	☐	☐	Routine laxative use
☐	☐	☐	Head injury	☐	☐	☐	Chronic Constipation
☐	☐	☐	Seizures	☐	☐	☐	Changes in bowel movement
				☐	☐	☐	Black or tarry stools
☐	☐	☐	Trouble with eyes/seeing	☐	☐	☐	Blood in stool
☐	☐	☐	Trouble with ears/hearing	☐	☐	☐	Hemorrhoid troubles
☐	☐	☐	Frequent nosebleeds				
☐	☐	☐	Frequent sinus problems	☐	☐	☐	Pain in your muscles
☐	☐	☐	Chest pain or pressure	☐	☐	☐	Hives
				☐	☐	☐	Lightheadedness or Dizziness
☐	☐	☐	Hot flashes	☐	☐	☐	Pain or swelling in joints
☐	☐	☐	Problem chewing or swallowing	☐	☐	☐	Numbness or weakness in arms/legs
☐	☐	☐	Frequent sore throats	☐	☐	☐	Feel Depressed
☐	☐	☐	Hoarseness	☐	☐	☐	Varicose Veins
☐	☐	☐	Persistent lumps in neck				
☐	☐	☐	Constant cough	☐	☐	☐	Abdominal Pain
☐	☐	☐	Coughing up phlegm or blood	☐	☐	☐	Change in Sleep
☐	☐	☐	Shortness of breath	☐	☐	☐	Feel Nervous/Anxious