Primary PartnerCare®

NEW PATIENT MEDICAL HISTORY FORM

Full Name:______________________________ Date:__________

Birth Date:______________ ______________ Age: __________

ALLERGIES

☐ No Allergies

ALLERGY	ALLERGY ALLERGIC REACTION

MEDICATIONS

MEDICATIONS (Please list all)	DOSES (Mg., pill, etc.)	TIMES PER DAY	PRESCRIBING PROVIDER

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH SCREENING HISTORY

Colonoscopy	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
Mammogram	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
Pap Smear	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
Diabetic Eye Exam	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	Last COVID-19 Vaccine/Booster:

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type:________________________________)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:______________________________)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Full Name:____ DOB:____________

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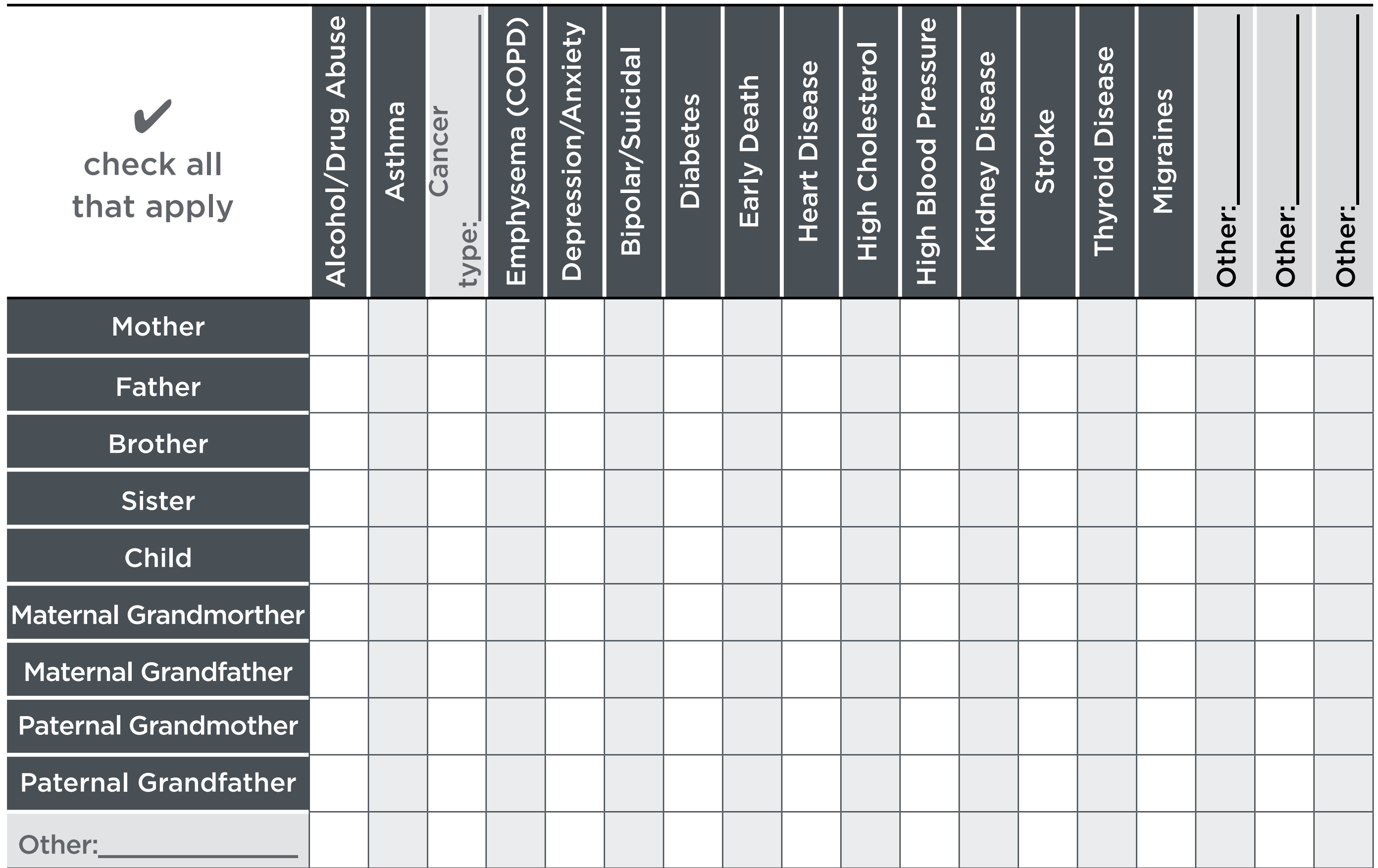
FAMILY MEDICAL HISTORY



✔ check all that apply	Alcohol/Drug Abuse	Asthma	Cancer type:___	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:___	Other:___	Other:___
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmorther																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:______________																		

SOCIAL HISTORY

Occupation (or prior occupation):

Employer:	Years of Education or Highest Degree:

Marital Status (check one): ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other:______________________

Do you have children? ☐ Yes ☐ No	If yes, how many?

OTHER HEALTH ISSUES

Tobacco Use — Smoke Cigarettes? ☐ Yes ☐ No (If you never smoked, please move to Alcohol /Drug Use)

Current: Packs/day _____ # of Years _____ | **Past:** Quit Date: ____________________ Packs/day _______ # of Years _______

Alcohol/Drug Use — Do you drink alcohol? ☐ Yes ☐ No | ☐ Beer ☐ Wine ☐ Liquor | # of Drinks/week:

Do you use marijuana or recreational drugs? ☐ Yes ☐ No | Have you ever used needles to inject drugs? ☐ Yes ☐ No

Have you ever taken someone else's drugs? ☐ Yes ☐ No

Full Name:____ DOB:__________

OTHER HEALTH ISSUES (continued)

Sexual Activity Sexually involved currently? ☐ Yes ☐ No (If no sexual history, please continue to Exercise)

Sexual partner(s) is/are/have been: ☐ Male ☐ Female

Birth control method: ☐ None ☐ Condom ☐ Pill/Ring/Patch/Inj/IUD ☐ Vasectomy

Exercise Do you exercise regularly? ☐ Yes ☐ No (If you answered no, please move to Sleep)

What kind of exercise? ______________________ Duration: How long (min.): _________ How often: _________

Sleep How many hours, on average, do you sleep at night (or during the day, if working night shift)?

Diet How would you rate your diet? ☐ Good ☐ Fair ☐ Poor Would you like advice on your diet? ☐ Yes ☐ No

Safety Do you use a bike helmet? ☐ Yes ☐ No Do you use seat belts consistently? ☐ Yes ☐ No

Do you use seat belts consistently? ☐ Yes ☐ No If you have guns at home, are they locked up? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No Have you completed a Living Will? ☐ Yes ☐ No

Have you completed a Health Care Proxy Form? ☐ Yes ☐ No

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: ______________		
Other: ______________		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? ☐ Yes ☐ No If yes, where?

Have you served in the military? ☐ Yes ☐ No If yes, how long and what branch?

Were you deployed? ☐ Yes ☐ No If yes, where?

Full Name: ____ DOB: ____________

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REVIEW OF SYSTEMS ✔ check all that apply

	CONSTITUTION
	Activity change
	Appetite change
	Chills
	Diaphoresis
	Fatigue
	Fever
	Unexpected weight change
	HEAD, EAR, NOSE & THROAT
	Congestion
	Dental problem
	Drooling
	Ear discharge
	Ear pain
	Facial swelling
	Hearing loss
	Mouth sores
	Nosebleeds
	Postnasal drip
	Rhinorrhea
	Sinus pressure
	Sneezing
	Sore throat
	Tinnitus
	Trouble swallowing
	Voice change
	EYES
	Eye discharge
	Eye itching
	Eye pain
	Eye redness
	Photophobia
	Visual disturbance
	RESPIRATORY
	Apnea
	Chest tightness
	Choking
	Cough
	Shortness of breath
	Stridor
	Wheezing

	CARDIOVASCULAR
	Chest pain
	Leg swelling
	Palpitations
	GASTROINTESTINAL
	Abdominal distention
	Abdominal pain
	Anal bleeding
	Blood in stool
	Constipation
	Diarrhea
	Nausea
	Rectal pain
	Vomiting
	ENDOCRINE
	Cold intolerance
	Heat intolerance
	Polydipsia
	Polyphagia
	Polyuria
	GENITOURINARY
	Difficulty urinating
	Dysuria
	Enuresis
	Flank pain
	Frequency
	Genital sore
	Hematuria
	Penile discharge
	Penile pain
	Penile swelling
	Scrotal swelling
	Testicular pain
	Urgency
	Urine decreased
	MUSCULAR
	Arthralgias
	Back pain
	Gait problems
	Joint swelling
	Myalgias
	Neck pain
	Neck stiffness

	SKIN
	Color change
	Pallor
	Rash
	Wound
	ALLERGY/IMMUNO
	Environmental allergies
	Food allergies
	Immunocompromised
	NEUROLOGICAL
	Dizziness
	Facial asymmetry
	Headaches
	Light-headedness
	Numbness
	Seizures
	Speech difficulty
	Syncope
	Tremors
	Weakness
	HEMATOLOGIC
	Adenopathy
	Bruises/bleeds easily
	PSYCHIATRIC
	Agitation
	Behavior problem
	Confusion
	Decreased concentration
	Dysphoric mood
	Hallucinations
	Hyperactive
	Nervous/anxious
	Self-injury
	Sleep disturbance
	Suicidal ideas

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