

All Patients: please complete pages 1,2 & 3 and SIGN at end of page 3

Prime HealthCare History

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

8	9	10	11	12	13	14	15	16	>16
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Who suggested our office to you?

A physician referred me	Who?
A friend referred me	Who?
Other	Explain
Who is your primary care MD?	

Please state in one or two sentences the major reason for your visit.

Please list all previous operations with approximate dates. Circle None if appropriate.

1) None	6)
2)	7)
3)	8)
4)	9)
5)	10)

Please check the boxes next to all illnesses you have or have had.

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Excessive Alcohol Use |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Liver Cirrhosis | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer: Colon | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Cancer: Esophagus | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Cancer: Stomach | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Cancer: Pancreas | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Cancer: Prostate | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sprue | <input type="checkbox"/> Cancer: Breast | <input type="checkbox"/> Arthritis |

List any other illnesses. Circle None if appropriate.

1) None	4)
2)	5)
3)	6)

I have reviewed the Prime HealthCare History

Physician Signature: _____ Date: ____ / ____ / ____

Please list any family members who have had any of the following problems.

Disease	Relation to you	Disease	Relation to you
Cancer: Colon		Colon Polyps	
Cancer: Esophagus		Crohn's Disease	
Cancer: Stomach		Ulcerative Colitis	
Cancer: Breast		Lactose Intolerance	
Sprue		Bleeding Problems	
Diabetes		Heart Disease	
Anemia		Alcohol Abuse	
Gall Bladder Stones		Hepatitis	
Liver Disease (cirrhosis)		Other	

List all your medications (including aspirin & laxatives). Circle None if appropriate

Name of Drug	Dose? (e.g. mg.)	How Often?
None		
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		

List all your medication allergies. If none are known, circle None.

None	3)	6)
1)	4)	7)
2)	5)	8)

Please circle the term that best describes your current employment status & describe.

Employed	Describe:
Retired	Previous job:
Unemployed	Previous job:
Student	Where?

Describe your use of the following: Circle None if appropriate.

Tobacco Use	None	___ Packs per day for ___ years	Stopped ___ years ago
Alcohol Use	None	Amount:	Stopped ___ years ago
Illegal Drug Use	None	Type & Amount:	Stopped ___ years ago
Coffee/tea	None	8 oz. cups per day:	

Please circle your answer:

Have you been vaccinated against hepatitis B?	Yes - No - Don't Know
Do you wish to be screened for colon cancer?	Yes - No - Don't Know

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Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms			Physician Comment
Lack of energy	Yes	No	Constitutional
Trouble sleeping	Yes	No	
Weight Loss (10 lbs in 1 yr)	Yes	No	
Weight gain (10 lbs in 1 yr)	Yes	No	
Fevers	Yes	No	
Hard or infrequent bowel movements	Yes	No	GI
Loose or frequent bowel movements	Yes	No	
Blood in bowel movements	Yes	No	
Vomit blood	Yes	No	
Heartburn/Indigestion	Yes	No	
Food sticks when swallowing	Yes	No	Cardiovascular
Painful swallowing	Yes	No	
Yellow jaundice	Yes	No	
Chest pain	Yes	No	
Irregular heartbeat	Yes	No	
Palpitations	Yes	No	Respiratory
Swollen legs	Yes	No	
Fainting	Yes	No	
Shortness of breath	Yes	No	
Wheezing	Yes	No	
Coughing up blood	Yes	No	GU
Asthma	Yes	No	
Frequent urination	Yes	No	
Blood in urine	Yes	No	
Difficulty urinating	Yes	No	
Could you be pregnant	Yes	No	Musculoskeletal
Painful menses	Yes	No	
Joint swelling	Yes	No	
Joint redness	Yes	No	
Gout	Yes	No	
Muscle aches	Yes	No	Breast/Skin
Breast lump	Yes	No	
Unusual or new rash	Yes	No	Neuro
Paralysis	Yes	No	
Stroke	Yes	No	
Seizures	Yes	No	
Loss of memory	Yes	No	
Depression	Yes	No	Psychological
Do you feel safe in current relationship	Yes	No	
Anxiety	Yes	No	
Diabetes	Yes	No	Endocrine
Excessive thirst	Yes	No	
Bleeding	Yes	No	Hemo
Easy bruising	Yes	No	
Allergy to shellfish	Yes	No	Allergy
Allergy to X-ray dye	Yes	No	

Patient's Signature _____

Date _____

