HOWARD COUNTY
Direct Primary Care

PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name: Date of Birth:

Date you are filling out this form:

What is the reason for your visit?

TELL US ABOUT YOURSELF:

Home situation:
Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____ Children?_____ Are they healthy?_____

Employment:
Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation:_____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____
Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

PAST MEDICAL HISTORY:
Please list diseases from which you currently suffer:

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drugs and type of reaction.

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives.

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer, please specify								
Heart disease								
Diabetes								
High blood pressure								
Stroke								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

SYMPTOM/SYSTEM REVIEW

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ palpitations
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular heartbeat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs

pain, weakness or numbness in:
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ seizures

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever/chills
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ rash
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ date of last Pap smear:_____
- ☐ bleeding between periods
- ☐ date of last period:_____
- ☐ date of last mammogram:_____

Men only
- ☐ History of abnormal PSA

IMMUNIZATIONS: if YES, give approximate year given

Pneumonia	No_____	Yes_____
Shingles	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____
Influenza	No_____	Yes_____

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT