NorthBay Center for Primary Care

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YOUR MEDICAL HISTORY

Please take a few moments to tell us about your medical history. While this form will take a few minutes to complete, it will help us to understand your health needs. It will also help us to work together with you to develop a plan of care. Thank you.

1. Do you take any medications regularly? Yes ____ No ____

2. Please list any operations or hospitalizations you've had and their dates:

_____
_____
_____
_____

3. When was your last tetanus shot?_____
4. When was your last pneumovax shot? _____
5. Please indicate whether you've had health problems or treatment for the following conditions:

Heart & Blood	Yes	No	Not Sure
Chest pain or angina			
Heart attack			
High blood pressure			
Heart murmur			
Irregular pulse			
Elevated cholesterol			
Dizziness			
Anemia			
Easy bleeding or bruising			
Blood transfusion: If yes, when?			
Taking blood thinners			
Skin			
Rashes			
Eczema or psoriasis			
Other skin problems			

Muscles and Joints			
Swelling or pain in joints/arthritis			
Swelling or pain in legs			
Back problem			
Gastrointestinal			
Frequent constipation or diarrhea			
Blood in bowel movements			
Ulcers			
Gastrointestinal (continued)	Yes	No	Not Sure
Hepatitis B or C			
Gallstones			
Gastro-esophageal reflux disease or GERD			
Hemorrhoids			
Neurologic			
Seizures			
Migraines			
Stroke			
Headaches			
Head Injury			
Concussion			
Eyes			
Glaucoma			
Vision Loss			
Ears			
Hearing Loss			
Psychiatric			
Depression			
Manic depression (bipolar)			
Sleep difficulties			
Alcohol abuse			
Panic Disorder			
Drug Abuse			
Endocrine			
Diabetes			
Thyroid Disease			
Hormone replacement therapy			
Prednisone or other steroid hormone therapy			
Genitourinary / Renal			
Kidney disease			
Loss of bladder control			

Kidney stones			
Sexually transmitted disease / HIV			
Sexual difficulties			
If male, prostate problems			
If female, uterus / ovary disease			
Trouble urinating or passing water			
Cancer			
Have you had cancer? If yes, what type?			
If yes, did you have radiation therapy?			
If yes, did you have chemotherapy?			
Respiratory	Yes	No	Not Sure
Asthma			
Emphysema			
Pneumonia			
Sinus infection			
Other health problems			

6. For Females

When was the first day of your last period?		
At what age did you have your first period?		
Do you have problems with your periods such as severe cramps, irregular periods, or heavy bleeding?		
Current form of contraception		
Number of pregnancies		
Number of live births		
Number of abortions or miscarriages		
Last pap		
Last mammogram		

7. What is the biggest worry about your health?

_____

_____

_____

8. Family medical history– Please indicate if any family member has had the following:

	Yes	No	Relationship
Cancer - type			
Blood pressure problems			
Heart problems/chest pain			
Bleeding problems			
Diabetes			
Epilepsy/seizures			
Asthma/breathing problems			
Reaction to anesthesia			
Cholesterol			

9. Social Occupation	Yes	No
Are you: married or in a long term relationship		
single		
divorced		
widowed		
Do you have children? If yes, how many?		
Who lives at home?		
Do you have an advance directive or a living will?		
Do you smoke? If yes, how many cigarettes per day?		
	Yes	No
Do you drink alcohol? If yes, how many drinks per week?		
What is your caffeine intake?		
Last eye exam?		
Last dental exam?		

10. Travel History in last 6 months	Yes	No
Location:		

_____

Date and Time **Patient Signature** **Relationship to Patient**

Date Reviewed by Physician _____Signature_____

Last Name, First_____

Med Rec# _____**PCP**_____

DOB:_____ **Age** _____ **CPC-29 Rev. 02/12**

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Medical History