PRIMECARE 360

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Health and Medical History Form

** Please fill out this form as completely as possible. A thorough patient and family history is pertinent in indentification and treatment of many conditions. If you are unsure about some of the information, please ask

Personal History: {Please mark all conditions you are currently diagnosed with, or have been diagnosed with in the past.

Cardiovascular:
- ☐ Arrhythmias
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other:.....

Digestive:
- ☐ IBS {Constipatin/Diarrhea)
- ☐ Crohn's or Colitis
- ☐ Diverticulosis
- ☐ Gastroesophageal Reflux
- ☐ Ulcers
- ☐ Other:.....

Endocrine:
- ☐ Diabetes {Type ----------)
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disease
- ☐ Other:----------

Lymphatic:
- ☐ Lymphedema
- ☐Other:----------

Integumentary: (Skin)
- ☐ Acne
- ☐ Cold Sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other:.....

Nervous:
- ☐ Alzheimers / Dementia
- ☐ Headaches / Migraines
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke{s)
- ☐ Other:.....

Genitourinary:
- ☐ Chronic Kidney Disease
- ☐ Incontinence
- ☐ Kidney / Bladder Stones
- ☐ Enlarged Prostate / BPH
- ☐ Recurrent UTI
- ☐ Other:----------

Respiratory:
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD / Emphysema
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Other:.....

Reproductive:
- ☐ Endometriosis / Fibroids
- ☐ Infertility
- ☐ Low Testosterone
- ☐ Sexually Transmitted Disease
- ☐ Sexual Dysfunction
- ☐ Other:.....

Musculoskeletal:
- ☐ Chronic Back Pain
- ☐ Osteopenia / Osteoporosis
- ☐ Sciatica
- ☐ Other:.....

Surgeries: {Please list all surgeries with year it was performed.)

_____

_____

_____

Hospitalizations: {Please list the cause for each hospitalization with the year it occurred.)

_____

_____

_____

Immunizations: Please list the vaccine and date recieved.

COVID: _____{Mod., Pfiz., J&J) Booster{s): _____{Mod., Pfiz., J&J)

Tetnus: _____ Influenza:..... Pneumonia: ..... Shingles: _____

Family History: Please list medical conditions of each family member.

**If the person is living, please list age, if deceased, please list age of death and cause if known.

Family Member	Conditions	Age	Deceased	Cause of Death
Mother:			y / N	
Father:			y / N	
Maternal Aunts/Uncles:			y / N	
Paternal Aunts/Uncles:			y / N	
Maternal Grandmother:			y / N	
Maternal Grandfather:			y / N	
Paternal Grandmother:			y / N	
Paternal Grandfather:			y / N	

Is there family history of any forms of cancer? {Please list what kind and your relationship.)

_____

Are there any other things you would like us to know about your family history?

_____

Social History:

What is your relationship status?{Circle One Married Single Divorced Separated Widowed

Do you have any children? If so, please list age, sex, and medical conditions, if any.

_____

_____

_____

Are you employed? If so, where? ---------- Work from home? y / N

Do you do any of the following? If so, please specify whether a past or current user, and for how long.

	Current Use?	Past Use?	If past use, what kind and how long go did you quit?
Cigerettes, cigars, or smoked tobacco:	y / N	y / N	_____
Vape products:	y / N	y / N	_____
Smokeless / Oral Tobacco:	y / N	y / N	_____
Caffiene {coffee, tea, soda, etc.):	y / N	y / N	_____
Alcohol:	y / N	y / N	_____
Drug Use:	y / N	y / N	_____
Marijuana Use:	y / N	y / N	_____