Primary Medical Associates of Long Island ***Patient Health Assessment Form*** Date: _____

Medications (please include dosage (mg, mcg, once/twice a day) & prescriber & all herbal medications & vitamins)

1._____ Dose/Frequency:_____ Prescriber: _____
2._____ Dose/Frequency:_____ Prescriber: _____
3._____ Dose/Frequency:_____ Prescriber: _____
4._____ Dose/Frequency:_____ Prescriber: _____
5._____ Dose/Frequency:_____ Prescriber: _____

Reason for Today's visit:_____

Medical History

Current or Past Problems with:	Yes	No	(If Yes, please explain)
Asthma			
Allergies			
Anemia			
Arthritis/joint pains			
Black outs			
Breathing trouble			
Back pain			
Blood/bleeding disorder			
Chest pain			
Cancer			
Diabetes			
Dizziness/Vertigo			
Emphysema/COPD			
Eye disorders			
Ear/Nose/Throat			
Heartburn/Acid reflux			
Heart Attack/ Heart problems			
Hiatal hernia			
High Cholesterol			
Headache			
Hearing difficulty			
High blood pressure			
Hepatitis/Liver failure			
Kidney disorder/failure			
Meningitis			
Seizures			
Skin			
Stomach/bowel			
Stroke			
Swollen legs			
Thyroid disorder			

Family History

Disease	Mother	Father	Sibling	Other Blood Relative
Allergies				
Arthritis				
Cancer				
Heart Problems/Heart Attack				
High Cholesterol				
Kidney disorder/failure				
Stroke				
Diabetes				
Blood/bleeding disorder				
Thyroid disorder				

Allergies: (medications, food, environmental)
If yes, please explain:
_____
_____

Surgical History: _____
_____
_____

Disability: Have you ever been considered **disabled?**
If yes, please explain:
_____
_____

Social history:
Do you currently smoke? _____
If so, how many packs per day? _____
For how many years/how much? _____
Did you smoke in the past? _____
How many years ago did you quit? _____
Do you drink? _____
Drink type _____
Drinks per day/week _____
Illicit drug use? _____

Preventative Care:
Last Physical: _____
Last time blood was drawn: _____
Last Dentist visit: _____
Last Ophthalmologist visit: _____
Last Colonoscopy: _____
Influenza vaccine: _____
Pneumonia vaccine: _____
Do you have a living will?_____
A health care proxy? _____

Males:
Last prostate exam: _____
Last Prostate specific antigen (PSA): _____

Females:
Last menstrual period (LMP): _____
Last PAP smear: _____
Last Breast exam: _____
Last Bone Density (Dexa) scan:_____
Last Mammogram:_____
Are you Pregnant? _____

Signature: _____

Date: _____