WELCOME TO PRECISION HEALTH CARE

MEDICAL HISTORY FORM

NAME _____ ***AGE*** _____

Your answers in this form will help your provider understand your medical condition and concerns better. Answer as much as possible.

How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

Main Reason for Today's Visit _____

Other concerns I would like to discuss if there is time _____

Please circle any CURRENT symptoms you have:

Constitutional: Fever Chills Unexplained -weight loss / gain Weakness Fatigue Night sweats Problems sleeping
Eyes: Blurry of vision Double vision Redness Discharge Dry eyes
Ear/Nose/Throat/Mouth : Difficulty hearing Ringing ears Earache Nasal drainage Sore throat Postnasal drainage Nose bleed
Cardiovascular: chest pain / Discomfort Palpitations
Respiratory: Shortness of Breath / Difficulty breathing Cough Sputum Wheezing Blood in sputum
Breast : Breast lump Nipple discharge Pain
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Pain Black stool Blood in stool Heartburn Indigestion Bloating
Genitourinary: Discharge vagina Itching Unusual vaginal bleeding Pain Frequency / Pain with urination Leaking urine Pain with sexual Intercourse
Musuloskeletal: New bone pain Joint pain Back pain Leg cramps
Skin: Skin lesions Rash Discoloration Jaundice Eczema
Neurological: Fainting Weakness Headache Seizure Dizzy Numbness Tingling
Psychiatry : Depression Anxiety
Endocrine: : Excessive thirst Night time urination Hotflashes Dry skin Cold hands and feet Dry brittle rough sparse hair
Blood / Lymphatics : Easy bruising Swollen lymphnodes Bleeding

- **In the past month have you had little interest or pleasure in doing things that I used to enjoy before. □ Yes □ No**
- **Felt down depressed or hopeless. □ Yes □ No**

Personal Medical History

□ ***Heart Disease Specific Type*** _____ □ ***High Blood Pressure*** □ ***Diabetes*** □ ***High Cholesterol***
□ ***Thyroid problem*** □ ***Lung Problems***
□***Other*** _____

_____

Personal Surgical History (please list all operations , month/year)

_____

_____

Medications :(prescription, over the counter , vitamins , herbs)(Dose mg/pill)(How many times per day?)

_____

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Allergies or Reactions to medicines

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Family History: ***Any family member with any of these diseases ?***

□***Cancer*** □***Diabetes*** □***High Blood Pressure*** □***Mental Illness*** □***Bleeding Problems***

□***Heart Problem*** □***Asthma*** □ ***Sroke***

Social History:
□ ***Marital Status***_____
□ ***Children***_____
□ ***Occupation*** _____
□ ***Exercise***_____
□ ***Diet***_____
□ ***Tobacco/Cigerrete*** _____
□ ***Alcohol*** _____
Safety: ***Do you use bike helmets?*** □ ***Yes*** □ ***No*** □ ***N/A***
Do you use seatbelts consistently? □ ***Yes*** □ ***No***
Is VIOLENCE at home a concern for you? □ ***Yes*** □ ***No***
Have you ever been ABUSED? □ ***Yes*** □ ***No***
Do you have GUN at home ? □ ***Yes*** □ ***No***

Women's Health History: ***#pregnancies_____ #deliveries _____ #abortions_____ # miscarriages_____***
Normal Delivery_____ C-Section_____
What age you started having menstrual cycles? _____ 1st day of Last Menstrual period_____
Menses --- Every How Many Days _____ , Duration_____days, □ ***Heavy*** □ ***Moderate*** □ ***Light ,***
Cramps □***Yes*** □***No***

Additional Remarks

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Please Sign Here _____ Date _____