Medical and Personal History

Patient Name: _____

Date: _____

Seacoast Direct Primary Care

Phone: _____

Email: _____

Address: _____

_____

DOB: _____

Gender: _____

Please check conditions which you have had and when.

Cardiovascular

- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ CHF
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Chest pain
- ○ Abnormal stress test
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries
- ○ Swelling in legs

Endocrine

- ○ Diabetes Mellitus
- ○ Overactive Thyroid
- ○ UnderactiveThyroid
- ○ Anemia
- ○ Thyroid Goiter
- ○ Weight loss
- ○ Weight gain

Skin

- ○ Eczema / Psoriasis
- ○ Shingles
- ○ Atypical Mole
- ○ Hives

Respiratory

- ○ Sleep Apnea ;Snoring
- ○ Frequent lung infection
- ○ Emphysema /COPD
- ○ Asthma
- ○ Clots in Lungs
- ○ Daily cough

Musculoskeletal

- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Joint Pain
- ○ Gout
- ○ Broken Bones
- ○ Osteoporosis
- ○ Osteopenia
- ○ Fibromyalgia
- ○ Neck Pain (hern. disc)
- ○ Back Pain (herniated disc)

Neurologic

- ○ Seizure
- ○ TIA / Stroke
- ○ Numbness
- ○ Weakness
- ○ Memory Loss
- ○ Migraine headaches
- ○ Dizziness
- ○ Vertigo

Psychiatric

- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Suicide Attempt
- ○ Physical Abuse
- ○ Sexual Abuse
- ○ Bipolar
- ○ Hallucinations
- ○ Insomnia
- ○ Alcohol/drug addiction

Gynecology

- ○ Irregular Menses
- ○ Endometriosis
- ○ Birth control history

  _____

  _____
- ○ No menses
- ○ Abnormal pap
- ○ Night sweats
- ○ Hot flash

- ○ Miscarriage
- ○ Abortion

Infection

- ○ Tuberculosis
  - ○ Lyme Disease
  - ○ HIV / Hepatitis / STD
  - ○ Hepatitis

GI /GU

- ○ Heartburn
- ○ Stomach Ulcers
- ○ Gallstones
- ○ Blood in Stool
- ○ Diarrhea / Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain
- ○ Colon Polyps
- ○ Urinary Frequency
- ○ Bladder Infections
- ○ Prostate Disease
- ○ Urinary Incontinence
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis

HEENT

- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Loss
- ○ Frequent Ear Infections
- ○ Ringing in Ears
- ○ Allergies
- ○ Frequent Sinus Infections
- ○ Mouth Sores

Allergies

_____

_____

_____

Medications and supplements including dose:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications tried and reason stopped:

_____ _____ _____

_____ _____ _____

Seacoast Direct Primary Care

Please indicate any surgeries you have had and the year you had them:

○ Angioplasty _____	○ Trauma Related _____	○ Stomach_____	○ Tubal Ligation _____
○ Carotid Artery _____	○ Back/neck _____	○ Inguinal Hernia _____	○ C-Section _____
○ Other Vascular _____	○ Hip _____	○ Colonoscopy _____	○ Hysterectomy _____
○ Coronary Bypass _____	○ Knee _____	○ Gallbladder _____	○ Ovary Removed _____
○ Chest/Lung _____	○ Carpal Tunnel _____	○ Appendectomy _____	○ Breast _____
○ Tonsillectomy _____	○ Sinus _____	○ Prostate _____	○ Thyroid _____
○ Neurosurgery _____	○ Ear_____	○ Bladder _____	○ Other _____

Please indicate when you last had any of the following preventative tests or services:

○ Cardiac Angiogram _____	○ Flu Vaccine _____	○ PSA Blood Test_____	○ Colonoscopy _____
○ Stress Test _____	○ Pneumonia Vaccine _____	○ Rectal Exam _____	○ Mammo/Breast Exam ____
○ EKG _____	○ Tetanus Vaccine _____	○ Colon Cancer Stool Test _	○ PAP Smear _____
○ Chest X-Ray _____	○ Hepatitis Vaccine _____	○ Flexible Sigmoidoscopy ____	○ Last Menstrual Period ____
○ Echocardiogram _____	○ Bone Density Test _____	○ Eye exam _____	○ Dental Exam _____

Family Medical History

Please check major illness in your family members and indicate which family member affected

○ Mental Illness	○ Diabetes Mellitus	○ Kidney Disease	○ Breast Cancer
○ Emphysema	○ Thyroid Disease	○ Epilepsy	○ Ovarian Cancer
○ Heart Disease	○ Anemia	○ Neurologic Disorder	○ Colon Cancer or polyps
○ High Blood Pressure	○ Hemophilia	○ Liver Disease	○ Prostate Cancer
○ High Cholesterol	○ Osteoporosis	○ Hepatitis	○ Skin Cancer

Parents alive? Y / N

Age of both _____

Siblings? Ages _____

Personal Information

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

What is or was your occupation? Who currently lives in your home?

Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home?

Are you sexually active? Yes No

History of tobacco abuse? Yes No Past Quit Date Years smoked Packs per year

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)?

How much alcohol do you consume? None # per week

Dietary restrictions?

Provider Signature: **MD**

Exercise type and frequency?

Seacoast Direct Primary Care

Review of Systems - Circle all that apply

General

Good health overall
Fatigue, chronic

Loss of appetite
Weight loss
Weight gain
Unexplained fever > 100
Unexplained chills

HEENT

Eye pain
Eye discharge
Watery / itchy eyes
Double vision
Loss of vision
Ear pain
Ear drainage
Ringing in your ears
Frequent sinus congestion / infection
Post nasal drip
Change in voice
Frequent sore throat

Heart

Chest pain with activity or at rest
Palpitations / skipped heart beat
Extra heart beat
Fast heart beat
High blood pressure
Pain in calf with walking
Swelling in legs
Purple hands or feet
Passing out

Respiratory

Shortness of breath
Daytime cough
Nighttime cough
Wheeze / Inhaler use
Snoring

Gastrointestinal

Daily nausea
Irritable bowel
Constipation / Diarrhea
Black stool
Bloody stool
Hemorrhoids

Genitourinary

Pain with urination
Urinate > 2 night
Testicle pain
Heavy periods
Painful periods
Pain with sex
Lack of sex drive
Low libido / inability to orgasm

Musculoskeletal

Small joint pain
Large joint pain
Neck / back pain
Muscle pain

Hematologic

Blood transfusions
Anemia
Swollen lymph nodes

Neurologic

Frequent headaches
Migraines
Tremor
Memory loss
Imbalance
Numbness of feet

Psychiatric

Anxiety
Depression
Inability to fall asleep
Difficulty concentrating
Suicidal thoughts

Breast

Breast pain
Nipple discharge

Endocrine

Excessive thirst
Hair loss
Change in skin color
Irregular periods
Always hot / always cold