Primary Care Medical Center of Gulfport, PLLC

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PATIENT HISTORY FORM

NAME _____ DATE _____ SSN _____

Please complete the information below to provide us with background on your personal health history. This information will remain confidential, and will be part of your patient record.

Which of the following illness have you had? *(Please check all that apply.)*

CHILDHOOD HISTORY

	HAVE HAD		HAVE HAD
MEASLES	☐	LEUKEMIA	☐
MUMPS	☐	RENAL DISEASE	☐
CHICKEN POX (VARICELLA)	☐	CANCER AS A CHILD	☐
RHEUMATIC FEVER	☐	JAUNDICE	☐
HEART DISEASE	☐	FEEDING PROBLEMS	☐

PATIENT/FAMILY MEDICAL HISTORY

	SELF	FAMILY		SELF	FAMILY
ACUTE MYOCARDIAL INFARCTION	☐	☐	OSTEOARTHRITIS	☐	☐
ALLERGIES, HAYFEVER	☐	☐	ARTHRITIS	☐	☐
ALZHEIMER'S OR DEMENTIA	☐	☐	RHEUMATISM	☐	☐
ANEMIA	☐	☐	OSTEOPOROSIS	☐	☐
SICKLE CELL	☐	☐	PANCREATITIS	☐	☐
BLEEDS EASILY	☐	☐	PEPTIC ULCER DISEASE	☐	☐
CANCER_____	☐	☐	PSYCHIATRIC DISORDERS	☐	☐
BREAST CANCER	☐	☐	ANXIETY	☐	☐
COLON CANCER	☐	☐	DEPRESSION	☐	☐
OVARIAN CANCER	☐	☐	RENAL DISORDERS	☐	☐
CORONARY ARTERY DISEASE	☐	☐	KIDNEY/BLADDER INFECTION	☐	☐
DIABETES MELLITUS	☐	☐	KIDNEY STONE	☐	☐
GALLBLADDER DISEASE	☐	☐	LUNG DISEASE	☐	☐
GLAUCOMA OR CATARACTS	☐	☐	ASTHMA	☐	☐
HEART DISEASE	☐	☐	BRONCHITIS	☐	☐
HEPATIC DISORDERS	☐	☐	PNEUMONIA	☐	☐
HEPATITIS, A	☐	☐	TUBERCULOSIS	☐	☐
HEPATITIS, B	☐	☐	SEIZURE DISORDER	☐	☐
HEPATITIS, C	☐	☐	EPILEPSY OR CONVULSIONS	☐	☐
JAUNDICE	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐
HIV INFECTION	☐	☐	SKIN DISEASE	☐	☐
HYPERTENSION	☐	☐	ECZEMA	☐	☐
MIGRAINE HEADACHE	☐	☐	STROKE SYNDROME	☐	☐
			THYROID DISORDERS	☐	☐

SOCIAL HEALTH HISTORY

ALCOHOL USE	☐YES ☐NO	DRUG USE	☐YES ☐NO
HOW OFTEN_____	AMOUNT_____	EXCERCISE ROUTINE	☐YES ☐NO
SMOKING	☐YES ☐NO	PHYSICAL DISABILITY	☐YES ☐NO
NUMBER OF PACKS PER DAY_____		ABLE TO PERFORM DAILY ACTIVITIES	☐YES ☐NO
CAFFEINE USE	☐YES ☐NO	RECENT LIFE CHANGING EVENT	☐YES ☐NO

SURGICAL HISTORY

	HAVE HAD/YEAR		HAVE HAD/YEAR
HEAD OR SKULL SURGERY	☐_____	SKIN SURGERY	☐_____
EYE SURGERY	☐_____	ORAL SURGERY	☐_____
EAR SURGERY	☐_____	BACK SURGERY	☐_____
ADENOID REMOVAL	☐_____	NECK SURGERY	☐_____
TONSIL REMOVAL	☐_____	HEART SURGERY	☐_____
SINUS SURGERY	☐_____	LUNG SURGERY	☐_____
KIDNEY SURGERY	☐_____	ABDOMINAL SURGERY	☐_____
KNEE SURGERY	☐_____	APPENDIX REMOVAL	☐_____
		HERNIA REPAIR	☐_____

GYNECOLOGICAL HISTORY

PREVIOUS PAP SMEAR	☐YES ☐NO YEAR_____	ARE YOU PREGNANT NOW?	☐YES ☐NO
CERVICAL DYSPLASIA	☐YES ☐NO	NUMBER OF PREGNANCIES_____	
HPV INFECTION	☐YES ☐NO	NUMBER OF ABORTIOINS_____	
UTI	☐YES ☐NO	NUMBER OF MISCARRIAGES_____	
PREVIOUS C-SECTION DELIVERY	☐YES ☐NO	SURGICAL PROCEDURES	☐YES ☐NO
LAST MENTRAL PERIOD	DATE_____	TUBAL LIGATION	☐YES ☐NO
CONTRACEPTION	☐YES ☐NO	APPENDECTOMY	☐YES ☐NO
METHOD (e.g. pills, IUD, etc.)	_____	TOTAL ABDOMINAL HYSTERECTOMY	☐YES ☐NO
SEXUALLY ACTIVE	☐YES ☐NO	VAGINAL HYSTERECTOMY	☐YES ☐NO

MEDICATIONS

Are you currently taking prescription medication? ☐YES ☐NO

If yes, which medication?_____

_____

_____

Are you currently taking any over-the counter medication, supplements, or herbal products? ☐YES ☐NO

If yes, which medication?_____

_____

_____

ALLERGIES

Please list any allergies that you have_____

_____

Which of these symptoms do you experience on a regular basis? *(Please check all that apply.)*

HEARTBURN	☐	UPSET STOMACH	☐
BREATHING/SWALLOWING PROBLEMS	☐	ABDOMINAL PAIN	☐
MORNING HOARSENESS	☐	NAUSEA OR VOMITING	☐
GAS, BLOATING, OR BELCHING	☐	"BACK WASH" OF STOMACH CONTENTS INTO THE MOUTH AT NIGHT	☐