UNIVERSITY PRIMARY CARE

PATIENT MEDICAL HISTORY

Patient's Name:_____ DOB: ___/___/____ Who referred you?_____

What is the primary reason for today's visit? _____

_____

Medications (please bring all medications to every visit)

Please list: _____

_____

Allergies Are you allergic to any drugs? ☐ Yes ☐ No

Please list: _____

Social History

Right or **Left** handed

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If yes, how many packs per day? _____

If no, have you in the past? ☐ Yes ☐ No When did you stop? _____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No How many drinks per week? _____

If no, have you in the past? ☐ Yes ☐ No If yes, when did you stop? _____

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you or have you ever used illegal drug? ☐ Yes ☐ No If yes, what drug and how often? _____

Do you exercise daily/weekly? ☐ Yes ☐ No

If yes, what type and how many times per week? _____

Current and Past Medical History (pleae check all that apply)

☐ Heart disease / Murmur / Angina ☐ Shortness of breath ☐ Eye disorder / Glaucoma ☐ Diabetes

☐ High cholesterol ☐ Asthma ☐ Seizures ☐ Kidney / Bladder problems ☐ High blood pressure

☐ Lung problems / Cough ☐ Stroke ☐ Liver problems / Hepatatis ☐ Low blood pressure ☐ Sinus problems

☐ Headaches / Migraines ☐ Arthritis ☐ Heartburn (reflux) ☐ Seasonal Allergies ☐ Neurological problems

☐ Cancer ☐ Anemia / Blood problems ☐ Tonsillitis ☐ Depression / Anxiety ☐ Ulcers / Colitis

☐ Swollen ankles ☐ Ear problems ☐ Psychiatric care ☐ Thyroid problems

Please describe any current or past medical treatment not listed above:

_____

_____