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Primary Care of Shelton, LLC

Name: _____ **DOB:** _____

Previous Medical Providers name and address:

If you would like us to know, who has referred you to our practice:

Occupation: _____

ALLERGIES: -

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE, INCLUDING VITAMINS AND SUPPLEMENTS) INCLUDE NAME, DOSAGE & FREQUENCY:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	PROBLEM/DATE

PERSONAL & SOCIAL HISTORY

Have you had a transfusion of blood or blood products? Yes No

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

Do you use cigarettes, pipes, cigars or chew tobacco? Yes No

Do you drink alcohol? Yes No If, yes answer questions below.

Do you use any street drugs or abuse prescription pain medication? Yes No

SOCIAL HISTORY: SHORT DESCRIPTION OF JOB, MARITAL STATUS AND LIVING CONDITION:

Have you ever been tested for HIV? Yes No

If yes, when ___/___/___ . What was the Result? ___

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
1. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
2. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		

FAMILY HISTORY		RELATIVE	RELATIVE
1. Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	11. Iron Storage Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	12. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	13. Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	14. Prostate Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Depression, Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	15. Skin Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	16. Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
7. High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	17. Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	18. Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	19. Macular degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	20. Other: _____

HEALTH MAINTENANCE; Last Stools, occult blood test: ___/___ Colonoscopy/Sigmoidoscopy: ___/___

Dental Exam: ___/___ Dilated Eye Exam: ___/___ Foot Exam: ___/___

WOMEN: Last: PAP smear: ___/___ Mammogram: ___/___ Breast Exam: ___/___ Menstrual Period: ___/___/___

MEN: Last: Rectal/Prostate exam: ___/___ Testicular Exam: ___/___ PSA: ___/___

IMMUNIZATIONS: (last date/year received): Tetanus: _____ Hepatitis B vaccine: _____ MMR: _____
Pneumonia: _____ Flu: _____ Tuberculosis Skin Test (date & results): _____

Please review the list of symptoms below.

Check “Yes” box if you suffer from the symptoms or have any of the health issues listed in the past 6 months. Check “No” box if you do not.

CONSTITUTIONAL	SKIN	MUSCULAR SKELETAL
Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No
Fevers <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin itching <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Chills <input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea or Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL	Locking joints <input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes	Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract <input type="checkbox"/> Yes <input type="checkbox"/> No	Change in movements <input type="checkbox"/> Yes <input type="checkbox"/> No	Red or Swollen in joints <input type="checkbox"/> Yes <input type="checkbox"/> No
Change in vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No	HEMATOLOGY/ONCOLOGY
Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia or low blood <input type="checkbox"/> Yes <input type="checkbox"/> No
Red eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily bruise <input type="checkbox"/> Yes <input type="checkbox"/> No
ENMT	Heart burn <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding from gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancers <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	Black tarry stool <input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC
Change in your voice <input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression or Sadness <input type="checkbox"/> Yes <input type="checkbox"/> No
Denture <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Feel like hurting someone <input type="checkbox"/> Yes <input type="checkbox"/> No
Nose bleeds <input type="checkbox"/> Yes <input type="checkbox"/> No	GENITOURINARY	Feel like hurting yourself <input type="checkbox"/> Yes <input type="checkbox"/> No
Hoarse voice <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems urinating <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with memory <input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernias <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems concentrating <input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No
CARDIOVASCULAR	Urination at night <input type="checkbox"/> Yes <input type="checkbox"/> No	NEUROLOGY
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual transmitted Dz. <input type="checkbox"/> Yes <input type="checkbox"/> No	Change in memory <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary urgency <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Leg pain with walking <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with your period <input type="checkbox"/> Yes <input type="checkbox"/> No	Imbalance <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal dryness <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in legs <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with sex <input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems lying flat <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No
Skipping heart beats <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in breast <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Short of breath at night <input type="checkbox"/> Yes <input type="checkbox"/> No	Lumps in breast <input type="checkbox"/> Yes <input type="checkbox"/> No	ENDOCRINE
RESPIRATORY	Breast discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	MEN ONLY	Problems with cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with erections <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in neck <input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing up blood <input type="checkbox"/> Yes <input type="checkbox"/> No	Dribbling of urine <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Weak urine stream <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in testicles <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in hair <input type="checkbox"/> Yes <input type="checkbox"/> No

Patient’s Signature: _____

Date: _____