Primary Health Group
Chippenham
HCA Va Physicians
AN HCA AFFILIATE

PATIENT INFORMATION:

TODAY'S DATE: _____

_____
Last Name, First Name, MI

_____
DOB (mm/dd/yyyy)

PERSONAL HISTORY:
Do you have or have you ever had the following:

Yes	No	Condition	Yes	No	Condition
☐	☐	Arthrities, if so which type? _____	☐	☐	Hernia
☐	☐	Asthma	☐	☐	High blood pressure
☐	☐	Blood clots	☐	☐	High cholesterol
☐	☐	Cancer	☐	☐	HIV
☐	☐	COPD/Emphysema	☐	☐	Infertility
☐	☐	Depression/anxiety	☐	☐	Kidney/bladder problems
☐	☐	Diabetes, Type I or Type II (circle one)	☐	☐	Liver disease/jaundice
☐	☐	Eating disorder	☐	☐	Lupus
☐	☐	Eye disorder If yes, which type?_____	☐	☐	Peripheral Vascular disease
☐	☐	Gastritis	☐	☐	Pneumonia
☐	☐	GERD/GI bleed, circle one	☐	☐	Seizures
☐	☐	Gout	☐	☐	Sexually transmitted disease
☐	☐	Hay fever/pollen allergy			If yes, which type? _____
☐	☐	Headaches	☐	☐	Sick cell anemia
☐	☐	Hearing Loss	☐	☐	Skin disorder, specify _____
☐	☐	Heart attack/Heart disease	☐	☐	Stoke, if so when _____
☐	☐	Heart murmur	☐	☐	Thyroid problem, specify _____
☐	☐	Hemorrhoids	☐	☐	Ulcers
☐	☐	Hepatitis, which type? _____	☐	☐	Other: (Specify) _____
			☐	☐	Other: (Specify) _____

PREVENTATIVE/SCREENING:
Have you ever had:

Screening	Yes	No	
Flu shot	☐	☐	If yes, when _____
Pneumovax shot	☐	☐	If yes, when _____
Tetanus shot	☐	☐	If yes, when _____
Prevnar shot	☐	☐	If yes, when _____
Shingles Shot	☐	☐	If yes, when _____
If > 40, a colonoscopy	☐	☐	If yes, when _____

For Women:
When was the first day of your LMP? _____
Last PAP smear _____ (mm/yy)? Have you ever had an abnormal PAP? **Y N**,
If yes, when? _____ (mm/yy)
Have you had 3 consecutive normal PAPs since you had an abnormal one? **Y N**
If > 40, Have you ever had a mammogram? **Y N** If yes, when _____ (mm/yy) If applicable, number of pregnancies? _____ Number of miscarriages _____ Number of live births _____

For Men:
PSA _____ mm/yy) Normal _____ Abnormal _____

ALLERGIES

SURGERY/ HOSPITALIZATION/ INJURY HISTORY

Please list any surgeries/hospitalizations/accidents: (include gynecological surgeries)

Operations/Condition requiring hospitalization	Year

PERSONAL HABITS

	Circle One		
Do you drink Alcohol?	**Yes**	**No**	If yes, how much per week?_____
Do you smoke cigarettes, cigars, or chew tobacco?	**Yes**	**No**	If yes, how many packs per day?_____ If yes, how many years? _____
Are you a former smoker?	**Yes**	**No**	If yes, how many packs per day?_____ If yes, how many years? _____
Do you/did you use street drugs?	**Yes**	**No**	If yes, what type?_____
Do you drink > 4 cups of caffeinated beverages per day?			If yes, what amount?_____
Do you exercise regularly?	**Yes**	**No**	If yes, how often?_____

FAMILY HISTORY:

Relative	Age	If deceased, age at death	Medical problems/cause of death
Mother			
Father			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Siblings			

MEDICATIONS with dosages and frequency (Please include Over the counter and herbal medications)

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.