

**MERCY GENERAL HEALTH PARTNERS
PRIMARY CARE NETWORK**

INITIAL PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

Address: _____ Telephone: Home _____ Work _____

Employer/Occupation: _____

Who is completing this form? _____ Church Affiliation: _____

Current/Main Medical Problems: _____

Wear Glasses? Y N Blind? Y N Wear Hearing Aid? Y N Deaf? Y N

What specifically do you want to be seen for or have covered at this visit? _____

PREVIOUS ILLNESSES

- | | | |
|------------------------------------|----------------------------|----------------------|
| _____ Tuberculosis | _____ Lung Disease | _____ Heart Problems |
| _____ Rheumatic Fever | _____ High Blood Pressure | _____ Ulcer |
| _____ Anemia / blood disease | _____ Sickle Cell Anemia | _____ Cancer |
| _____ Diabetes | _____ Thyroid Disease | _____ Kidney Disease |
| _____ Serious Injuries | _____ Neurological Disease | _____ Liver Disease |
| _____ Gallbladder Disease | _____ Mental Illness | _____ Other: _____ |
| _____ Sexually-transmitted disease | _____ Depression | _____ |

Please list hospitalizations, surgeries, accidents, operations or major illnesses

Year	Illness or Operation	Year	Illness or Operation

MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency

Over the Counter medications: _____

What supplements, vitamins or herbal preparations do you use? _____

ALLERGIES and ADVERSE REACTIONS

Medication / Food / Other	Year	Reaction / Symptoms

IMMUNIZATIONS

What year did you last have a: _____ Tetanus Shot _____ MMR Shot
 _____ Hepatitis B _____ Number of Hep B shots
 _____ Chicken Pox or Vaccine _____ Pneumonia Vaccine
 _____ Influenza Vaccine

FAMILY HISTORY

Check if any blood relative has suffered following – please indicate which relative

_____ Tuberculosis	_____ Lung Disease	_____ Heart Problems
_____ Rheumatic Fever	_____ High Blood Pressure	_____ Ulcer
_____ Anemia / blood disease	_____ Sickle Cell Anemia	_____ Cancer
_____ Diabetes	_____ Thyroid Disease	_____ Kidney Disease
_____ Serious Injuries	_____ Neurological Disease	_____ Liver Disease
_____ Gallbladder Disease	_____ Mental Illness	_____ Heart Disease
_____ Alcoholism	_____ Depression	_____ Other: _____

Father's age: _____ Cause of death if not living: _____
 Mother's age: _____ Cause of death if not living: _____
 Brother/Sister age: _____ Cause of death if not living: _____
 Brother/Sister age: _____ Cause of death if not living: _____
 Brother/Sister age: _____ Cause of death if not living: _____
 Brother/Sister age: _____ Cause of death if not living: _____
 Brother/Sister age: _____ Cause of death if not living: _____

SOCIAL HISTORY

_____ Tobacco Use How much? _____
 _____ Alcohol Use How much? _____
 _____ Caffeine Use How much? _____
 _____ Illegal Drug Use How much? _____

Are there smoke detectors in the home? _____ Do you regularly wear a seatbelt? _____
 Do you wear a helmet when bicycling? _____ Is there a handgun in the house? _____
 How often do you exercise? _____ Do you follow a special diet? _____
 Do you have a patient advocate/living will/advance directive? _____
 Have you had a blood transfusion? _____ Are you currently on disability? _____
 Level of schooling completed _____ Language used (English or other) _____

Are you presently employed/source of income? _____

Are you happy with your living conditions? _____ Can you perform your own personal grooming? _____

If you are 65 or older, have you fallen in the last 3 months? _____

List names and relationship of the other people living in your household:

Name	Relationship	Name	Relationship

Children's Names and Birth Years

Name	Birth Year	Name	Birth Year

REVIEW OF SYSTEMS

Please CHECK any **significant** problems you have had and CIRCLE any **current** problems you are having:

HEENT:

- Headaches/Dizziness/Fainting
- Eyes/Vision
- Ears/Hearing
- Hay Fever/Allergies
- Nosebleeds/Sinuses
- Mouth or Teeth
- Sore throats/hoarseness
- Goiter or Growth

GASTROINTESTINAL:

- Abdominal pain/indigestion
- Severe Nausea or Vomiting
- Change in stool habits, bleeding
- Change in appetite
- Hernia
- Hemorrhoids

NEUROLOGY:

- Seizure Disorder
- Stroke
- Numbness/tingling

CHEST/RESPIRATORY:

- Wheezing/coughing
- Shortness of Breath
- Pain/swelling arms/legs
- Chest pain/pressure
- Nipple Discharge
- Breast Lumps
- Heart fluttering

GENITOURINARY:

- Painful/burning/difficult urination
- Blood in urine
- Vaginal or penile discharge

HEMATOLOGY/

ENDOCRINOLOGY:

- Chills/Fever/Sweats
- Lack of Energy
- Heat/cold intolerance
- Frequent urination
- Weight Change

SKIN:

- Rash/itching/hives
- Bruise easily
- Lumps or growths

Birth Control Method: _____
 # Lifetime Sexual Partners _____

MUSCULOSKELETAL:

- Back/joint/muscle pain
- Tremor/weakness
- Joint Swelling
- Broken bones
- Chiropractic treatment
- Falling

PSYCHOLOGY:

- Alcoholism
- Difficulty sleeping
- Anxiety/Depression / Moodiness
- Physical Abuse
- Memory loss
- Mental Illness
- Other Problems

MEN ONLY:

Sexual Problems Prostate problems Testicular pain/swelling
 Do you perform Testicular Self-exams? _____ If yes, how often? _____

WOMEN ONLY:

Date of Last Mammogram: _____ Do you perform Breast Self-exams? _____ If yes, how often? _____
 Date of Last Pap Test: _____ Abnormal PAP results _____ Sexual Problems _____
 Date of Last Menstrual Period: _____ Age of Menstrual Onset: _____ Hot Flashes _____
 Flow: heavy moderate light Days of flow: _____ Length of Cycle: _____
 Pain/cramps w/menstrual flow _____ Irregular Periods _____ Bleeding between periods _____
 Number of Live Births _____ Number of Induced Abortions _____ Number of Miscarriages _____

At any time, have you been hit, hurt, threatened or frightened by a friend or relative? _____

At any time, has anyone forced you to have sexual activities? _____

Is there anything not covered here that you would like us to know about you or that concerns you?

 Patient Signature

 Date

 Provider Signature

 Date