ADVANCED PRIMARY & BEHAVIORAL HEALTH HISTORY
CONFIDENTIAL

Patient Name: _____ Today's Date _____

Age _____ Birth Date _____ Last Physical Examination (Date) _____

What is your reason for visit? _____

SYMPTOMS: CHECK (X) SYMPTOMS YOU CURRRENLTY HAVE OR HAVE HAD IN THE PAST YEAR.

___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Fever
___ Forgetfulness
___ Headache
___ Loss of Sleep
___ Loss of Weight
___ Nervousness
___ Numbness
___ Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in:
___ Arms ___ Legs
___ Hips ___ Neck
___ Back ___ Shoulders
___ Feet ___ Hands

GENITO-URINARY
___ Blood in Urine
___ Frequent Urination
___ Lack of Bladder Control
___ Painful Urination

___ Appetite Poor
___ Bloating
___ Bowel Changes
___ Constipation
___ Diarrhea
___ Excessive Hunger
___ Excessive Thirst
___ Gas
___ Hemorrhoids
___ Indigestion
___ Nausea
___ Rectal Bleeding
___ Stomach Pain
___ Vomiting
___ Vomiting Blood

Cardiovascular
___ Chest Pain
___ High Blood Pressure
___ Irregular Heartbeat
___ Low Blood Pressure
___ Poor Circulation
___ Rapid Heart Beat
___ Swelling of Ankles
___ Varicose Veins

___ Bleeding Gums
___ Blurred Vision
___ Crossed Eyes
___ Difficulty Swallowing
___ Double Vision
___ Earache
___ Ear Discharge
___ Hay Fever
___ Hoarseness
___ Loss of Hearing
___ Nose Bleeds
___ Persistent Cough
___ Sinus Problems
___ Vision – Flashes
___ Vision – Halos

Skin
___ Bruise Easily
___ Hives
___ Itching
___ Changes in Moles
___ Rash
___ Scars
___ Sore Throat That Won't Heal

Men Only
___ Breast Lump
___ Erection Difficulties
___ Lump in Testicles
___ Penis Discharge
___ Sore on Penis
___ Other

Women Only
___ Abnormal Pap
___ Bleeding Between Periods
___ Breast Lump
___ Extreme Menstrual Pain
___ Hot Flashes
___ Nipple Discharge

___ Painful Intercourse
___ Vaginal Discharge
___ Other
Date of Last Menstrual Period:
_____
Date of Last Mammogram:
_____
Are You Pregnant? _____
Number of Children ___

PLACE AN (X) BY THE CONDITION YOU HAVE OR HAVE HAD IN THE PAST:

___ Aids
____ Alcoholism
____ Anemia
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bleeding Disorders
____ Breast Lump
____ Bronchitis
____ Bulimia
____ Cancer
____Cataracts

___ Chemical Dependency
____ Chicken Pox
____ Diabetes
____ Emphysema
____ Epilepsy
____ Glaucoma
____ Goiter
____ Gonorrhea
____ Gout
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herpes

___ High Cholesterol
____ HIV Positive
____ Kidney Disease
____ Liver Disease
____ Measles
____ Migraine Headaches
____ Miscarriage
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Pacemaker
____ Pneumonia
____ Polio

___ Prostrate Problems
____ Psychiatric Care
____ Rheumatic Fever
____ Scarlet Fever
____ Stroke
____ Suicide Attempt
____ Thyroid Problems
____ Tonsillitis
___ Tuberculosis
____Typhoid Fever
____ Ulcers
____ Vaginal Infections
____ Venereal Disease

CURRENT MEDICATIONIS (Can list on the Back) **ALLERGIES**

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FAMILY HISTORY: Fill in health information about your immediate family:

Relation	AGE	State Of Health	Cause of Death	Mark (X) If your Blood Relatives Had Any of the Following Disease	Relation to You
Father				**Arthritis, Gout**	
Mother				**Asthma, Hay Fever**	
Brothers				**Cancer**	
				Chemical Dependency	
				Diabetes	
				Heart Disease, Strokes	
Sisters				**High Blood Pressure**	
				Kidney Disease	
				Tuberculosis	
				Other	

Hospitalization Year	**Hospital**	**Reason and Outcome**	**Pregnancy History Date of Birth**	**Complications If Any**

Mark (X) Which Substances You Use And How Much

_____ Caffeine

_____Tobacco

_____ Street Drugs

_____ Other

Have You Ever Had A Blood Transfusion? Yes No
If Yes, Please Give Dates:

Serious Illness/ Injuries	**Date**	**Outcome**

Pharmacy Name:

Pharmacy Number:

Mark (X) If Your Work Exposes You To The Following

Stress _____
Hazardous Substances _____
Heavy Lifting _____
Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in my health.

_____ _____
Signature **Date**

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative **Date**