Capital Primary Care Medical History Form

Date: ________________ Account # __________________

Your full Name: ____

Age: ___________ D.O.B: _______________ Place of birth: ____

Race or Nationality of parents: _________________________________ Religion: ________________________

Education: ______________________________ (*highest level attained*) Age on completion: ________

Occupation: _____________________________ How long: _______________

Where & when have you lived or traveled outside of the U.S. or Canada? ____________________________________

____

	Living	Age or Age at Death	Present health or Cause of Death
Father	Yes ____ No ___	____________________	__________________________________
Mother	Yes ___ No ___	____________________	__________________________________
Spouse	Yes ____ No ___	____________________	__________________________________

Present Marriage Year: __________________________ Previous Marriage year & duration: _____________

Brothers: No. Living ___________ Health ____

No. Dead ____________ Cause of death: ______________________________________

Sisters: No. Living ___________ Health ____

No. Dead ____________ Cause of death: ______________________________________

Children: No. Living ___________ Age & Health: ____________________________________

No. Dead ____________ Ages & Cause: _____________________________________

<u>Please circle illnesses which have occurred in any of your blood relatives</u>

Diabetes Cancer Bleeding tendency Kidney Disease Tuberculosis Thyroid Disease

Heart Disease Stroke High Blood Pressure Nervous Illness Allergy

<u>Please circle illnesses which have occurred in any of your blood relatives</u>

Diabetes Glaucoma Heart Trouble Syphilis Diabetes, insulin taking

Asthma Jaundice Gonorrhea Cancer Pneumonia

Kidney Disease Rheumatic fever Tuberculosis Thyroid Disease

Please list other illnesses not requiring an operation for which you were hospitalized:

____

____

Have you had serious injuries, broken bones, etc? _______ List: ______________________________

____

Have you had allergy or sensitivity to medicine or other substances? _______ Please describe: ________________

____

____

Do you use tobacco now? ______ How long? _________ In the past? _______ How long? _________

Type & daily amount? ____

Do you use alcoholic beverages?_______ Type? ____

Weekly amount? _______________________ How long? ____

Do you use the following beverages? Show DAILY amount Water _______ Coffee _______ Tea _______
Soft drinks ____________ Milk __________

Please check the diseases against which you have been immunized:
Smallpox ___ Tetanus ___ Typhoid ___ Polio ___ Influenza ___ Other _______________________________

Previous Operations: Please list, giving dates, hospitals, where performed, and name of surgeon.

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

Previous x-ray therapy or similar treatment ____

Medications: Please name or otherwise identify medicines now or recently used

1. ____ 5. ____

2. ____ 6. ____

3. ____ 7. ____

4. ____ 8. ____

Menstrual History: Last Period ____________ *(date of onset)* Periods are regular ____ Irregular _____

Number of pregnancies ______________ Numbers of Miscarriages ____________________

Have you taken Cortisone-type drugs? ______ Oral contraceptives? _________________________

Have you received a blood transfusion? ___________________ Date ____

Your weight dressed? _________ How ling have you been at this weight? ___________________________________

Please write the reason you came to Capital Primary Care at this time _______________________________________

____

What is your main medical problem now and how long have you had it? _________________________________

____

What is your main symptom? *(For example: pain in the chest, shortness of breath)* ____________________________

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Reviewed By Physician: _____________________________________ Date: ______________________