Duke Primary Care

Health History

Patient Information **Date: / /** **Medical Record #:**

Patient Name: _____ Sex: ☐ Male ☐ Female

Preferred Name: _____

Date of Birth: _____/_____/_____ Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Do you have any health concerns? If yes, please list: _____

_____

_____

Past Medical History

Check conditions that doctors have followed you for in the past:

- ☐ High blood pressure/ hypertension
- ☐ High cholesterol
- ☐ Liver disease
- ☐ Diabetes ("sugar")
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ Heart attack/bypass surgery
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Stomach problems
- ☐ Intestinal problems
- ☐ Reflux disease
- ☐ Glaucoma
- ☐ Psychiatric illness
- ☐ Arthritis
- ☐ Abnormal Pap
- ☐ Cancer (type and location): _____
- ☐ Other: _____

List any hospitalizations or surgeries you have had (including C-section): _____

_____

_____

List any drug allergies: _____

_____

Are you allergic to latex? ☐ Yes ☐ No

List all current medications (including vitamins, herbal supplements, and health food preparations):

_____

_____

_____

_____

_____

Preventive Care

When was your last:

Tetanus Booster _____ Flu Shot _____ Pneumonia Vaccine _____ Hepatitis Vaccine _____

Flexible Sigmoidoscopy/Colonoscopy _____ Bone Densitometry _____

Female Only

Do you perform breast self-exams? _____ Do you see an OB–GYN doctor? _____

When was your last mammogram? _____ When was your last Pap smear? _____

Male Only

Do you do a testicular exam? _____ Do you have any problem with erections? _____

When was your last prostate blood test (PSA)? _____ When was your last prostate/rectal exam? _____

PLEASE CONTINUE ON BACK OF FORM

Social Habits

Have you ever used tobacco products? ☐ Yes ☐ No

What kind? _____

How much? _____

For how many years? _____

Date quit _____

Do you drink alcohol? ☐ Yes ☐ No

How many drinks per week? _____

Have you ever felt the need to cut down? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No

What type? _____ How often? _____

How many glasses/cups of caffeine do you drink daily? _____ Do you have guns in your home? _____

Do you exercise outside of your job? _____ Do you wear seatbelts? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What is your occupation? _____

How do you learn best? ☐ Read it ☐ Tell me ☐ Show me How much education have you completed? _____

Family History

Check the appropriate boxes.

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/Sisters	Other
High Blood Pressure/Hypertension						
Heart Attack/Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/Location)						
Osteoporosis						
Thyroid Problems						
Mental Illness						
Glaucoma						

Please check any of the following problems that apply to you: ☐ **No problems**

General
- ☐ Fever
- ☐ Sweats

Allergy
- ☐ Seasonal symptoms
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Postnasal drip

Cardiovascular
- ☐ Chest pain *or* pressure
- ☐ Ankle swelling
- ☐ Palpitations

Daily Living
- ☐ Violence in your home
- ☐ Changes in functional ability
- ☐ Changes in eating habits
- ☐ Changes in sleeping habits

Ear/Nose/Throat
- ☐ Ear pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Postnasal drip

Endocrine
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

Eyes
- ☐ Blurred vision
- ☐ Changing vision

Genitourinary
- ☐ Urinary frequency
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Problems urinating
- ☐ Awaken at night to urinate
- ☐ Problems with sex
- ☐ Exposure to sexually transmitted disease

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Blood in stool

Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Hard to stop bleeding

Mental Health
- ☐ Insomnia
- ☐ Guilt
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

Musculoskeletal
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Muscle pains

Neurologic
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Weakness

Nutrition
- ☐ On a special diet
- ☐ Weight gain or loss greater than 10 pounds

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Shortness of breath with exertion

Skin
- ☐ Rash
- ☐ Changing mole
- ☐ Itching
- ☐ Slow-healing wounds

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