EASTERN SHORE DRIVE PRIMARY CARE
Patient Medical History Sheet

NAME: _____ SSN: _____ DATE: _____

Do you have or have you had any of the following conditions? (Please Check)

_ Seizures
_Headaches/Migraines
_Stroke
_Neurological problems
_Heart disease/Murmur/Angina
_High Cholesterol
_High blood pressure
_Rheumatic Fever
_Heartburn (reflux)
_Liver problems/Hepatitis
_Ulcer/colitis
_Kidney/Bladder problems
_HIV/AIDS
_STD (sexually transmitted diseases)
_Asthma
_Lung problems/cough
_Seasonal Allergies
_Anemia or blood problems
_Blood clots
_Thyroid problems
_Diabetes
_Arthritis
_Back problems
_Depression/Anxiety
_Drug/Alcohol
_Eye disorder/Glaucoma
_Cancer_____

Have you had labs done recently? _Y _N If so, where_____

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? _Yes _No

Please list_____

Medications

Please list_____

_____ (over)

Immunizations (include dates)

Hepatitis A_____
Pneumonia_____
TB test/results_____
OPV (polio)_____
Varicella_____

Hepatitis B_____
Influenza_____
DPT/Td (tetanus)_____
MMR (measles, mumps, rubella)_____

SOCIAL AND PREVENTIVE HISTORY

Do you currently smoke or chew tobacco? _Y _N If no, have you in the past? _Y _N
How many packs a day? _____

Do you drink alcohol, beer, or wine? _Y _N If no, have you in the past? _Y _N
How many drinks per week? _____

Do you currently drink coffee and/or tea? _Y _N If yes, how many cups per day? ____

Do you exercise daily/weekly? _Y _N

FAMILY HISTORY

Are any of your parents or sibling's deceased? _____

Has any member of your family (including children and parents) had any of the following illnesses? (Check)

Anemia of Blood disease
Diabetes
Heart disease
HIV disease/AIDS
Stroke
Liver disease
Thyroid
Arthritis
Other serious illness

Cancer
Glaucoma
High blood pressure
Mental Illness/ Depression
Kidney disease
Seizures
Asthma
High cholesterol

FEMALES: GYNECOLOGICAL HISTORY

How many times have you been pregnant? _____
Have you had an abnormal Pap smear? _____ Date of last Pap smear_____
Have you had a sexually transmitted disease? _____
Date of last mammogram _____
Have you ever had a breast biopsy? _Y _N Biopsy results_____

Patient/Legal Guardian Signature_____ Date_____