West Atlanta Primary care

Medical History

Date_____

Full Name _____ Date of Birth _____

Previous medical providers' names, contact & speciality _____

_____

ALLERGIES AND REACTIONS

_____

MEDICATIONS (Prescription & over the counter medicine) Include name, dosage & frequency (or attach a list)

PAST MEDICAL ILLNESSES

❑Alcohol/ Drug Addiction ❑ Cancer (type) ❑Gout ❑ Kidney Stone ❑Stroke

❑Anemia. ❑Breast ❑Ovarian ❑Hay Fever ❑Liver Disease ❑Thyroid

❑Aneurysm. ❑Colon ❑Uterine ❑Heart Disease. ❑Seizure ❑Tuberculosis

❑Anxiety Disorder Other_____ ❑Heart Murmur. ❑Sexually Transmitted

❑Arthritis ❑Crohn's Disease. ❑Hepatitis B or C disease type _____

❑Asthma ❑COPD/Emphysema ❑High Cholesterol ❑Sickle Cell Disease ❑Positive TB

❑Blood Disorder ❑Depression ❑HIV ❑ Sleep Apnea

❑Blood Clot. ❑Diabetes ❑Hypertension ❑Stomach Ulcer

Other_____

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FAMILY HEALTH HISTORY. ❑ADOPTED

FAMILY MEMBERS	MAJOR MEDICAL PROBLEMS	IF DECEASED - REASON	AGE AT DEATH
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			
Father			
Brother and Sisters			
Sons and Daughters			

SOCIAL HISTORY

Ocupation Maritial Status Children ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many?

Do you Smoke ❑ Yes ❑ No Packs per day? How many years?

Are you a former smoker? ❑ Yes ❑ No Year quit?

Do you chew tobacco ❑ Yes ❑ No

Do you do recreational/ illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or hazardous materials? ❑ Yes ❑ No

Do you have a living will ❑ Yes ❑ No Healthcare Proxy ❑ Yes ❑ No if so who?

Do you have a Advance Directive for Healthcare ❑ Yes ❑ No

HEALTH MAINTENANCE

Last menstrual period _____ Last Pap Smear_____ Last Mammogram _____

Last Colonoscopy _____ Last prostate cancer screening _____ Last bone scan _____

Immunizations: ❑ Pneumovax _____ ❑FLU_____ ❑Tetanus_____ ❑Hep A ❑Hep B

Shingles: ❑ _____

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REVIEW OF YOUR SYMPTOMS:

- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Night Sweats
- ❑ Weakness
- ❑ Fatigue
- ❑ Insomnia
- ❑ Change in hearing
- ❑ Change in Vision
- ❑ Runny Nose
- ❑ Nose Bleed
- ❑ Fever
- ❑ Blood in Sputum
- ❑ Shortness of Breath
- ❑ Persistent cough
- ❑ Chest Discomfort
- ❑ Palpitations
- ❑ Fainting
- ❑ Change in exercise tolerance
- ❑ Difficulty Swallowing
- ❑ Indigestion or heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Change in bowel Habit
- ❑ Blood in Vomit
- ❑ Blood in Stool
- ❑ Difficulty Urinating
- ❑ Trouble holding Urine.
- ❑ Frequent Urination
- ❑ Penis discharge
- ❑ Vaginal discharge
- ❑ Nipple discharge
- ❑ Breast pain
- ❑ Breast Lump
- ❑ Pain with intercourse
- ❑ Feeling too hot
- ❑ Feeling too cold
- ❑ Dizziness
- ❑ Headaches
- ❑ Memory Loss
- ❑ Numbness/ Tingling
- ❑ Tremor
- ❑ Mood Swings
- ❑ Anxiety
- ❑ Depression
- ❑ Skin rash
- ❑ Back pain
- ❑ Leg pain
- ❑ Leg swelling
- ❑ COVID +
- ❑ Other _____

REASON FOR YOUR VISIT TODAY IN ORDER OF PRIORITY:

PATIENT NAME _____ PATIENT SIGNATURE _____ DATE _____ TIME _____