PRIMARY CARE PARTNERS OF HAWAII

PAST MEDICAL HISTORY

PATIENT INFORMATION			DATE
Last name:	**First:**	**Middle:**	**DOB / /**

Medications		
Name	*Dosage*	*How often*

Allergies to Drugs/Foods/Substances	
Name	*Type of reaction-hives, swelling, abdominal pain…,*

Please indicate if you have had any of the following conditions

Allergies☐ Anemia☐ Anxiety☐ Asthma☐ Blood Transfusion☐ Cancer☐ Colitis☐ Colon Polyps☐ COPD☐ Depression☐ Diabetes☐ Emphysema☐ Fractures of the Bone☐ Glaucoma☐ Goiter☐ High Cholesterol☐ High blood Pressure☐ HIV☐ Heart Disease☐ Hepatitis☐ Kidney Disease☐ Liver Disease☐ Mental Illness☐ Migraines☐ Seizures☐ Stomach Disease☐ Sexually Transmitted Diseases☐ Stroke☐ Thyroid Disease☐ Tuberculosis☐ Positive☐ screening test for TB☐ Ulcers☐

Please list any other illnesses, disease or injuries;

Please list your surgeries or hospitalizations

Surgery or condition	*Year*	*Physician*

PRIMARY CARE PARTNERS OF HAWAII

PAST MEDICAL HISTORY

Health Screening Testing (When have you had these tests or procedures)		
Tetanus	HIV Screening	PAP Smear
Pneumonia Vaccine	STD Screening	Cholesterol Screening
Flu Vaccine	Diabetes Screening	Mammogram
Hep B Vaccine	Eye Exam	Colonoscopy or Stool for blood
Shingles Vaccine	Dental Exam	DEXA/Bone Density

Family Medical History (Please list any known medical problems for the following family memebers)		
Father	Father's Father	Father's Mother
Mother	Mother's Father	Mother's Mother
Brother	Paternal Aunts/Uncles	Maternal Aunts/Uncles
Sister	Paternal Cousins	Maternal Cousins
Children	Other	

Social History		
Smoking ☐Yes No☐	If yes; Packs per day: Years: Year Quit;	Chewing tobacco ☐Yes ☐No
Alcohol ☐Yes No☐	Drinks per; Day; Week; Month; Year; *Choose one*	
Recreational Drug use such as Marijuana; ☐Yes No☐ Other;		
Exercise ☐Yes No☐ Type;	Activity per; Week Month; *Choose one*	
Caffeine ☐Yes No☐ Servings per; Day; Month; *Choose one*		
Sexual Preference; Heterosexual☐ Homosexual☐ Bisexual☐		
Marital Status; Married☐ Divorced☐ Separated☐ Single in relationship☐ Single☐ Widowed☐		
Children;		
Religion;	Occupation;	
Diet; Regular☐ Vegan☐ Vegetarian☐ Lacto-vegetarian☐ Lacto-ovo vegetarian☐ Pescetarian☐		

PRIMARY CARE PARTNERS OF HAWAII

PAST MEDICAL HISTORY

Review of Symptoms-Currently or within the last year (*Please circle any that may apply*)		
Fever	**Red/dry/itching/pain of eyes**	**Recurrent gum disorders**
Chills	**Tinnitus/ringing of the ears**	**Persistent hoarseness**
Night Sweats	**Loss of Hearing**	**Recurrent sore throat**
Recent weight gain	**Frequent nosebleeds**	**Difficulty swallowing**
Recent weight loss	**Loss of smell or taste**	**Pain with swallowing**
Eyesight problems	**Frequent head colds**	**Chest pains**
Double vision	**Recurrent mouth sores**	**Irregular heart beat or fast heart beat**
Pain of the calf while walking	**Difficulty passing urine**	**Difficulty walking**
Recurrent swelling of ankles or feet	**Blood in urine**	**Trouble with memory**
Shortness of breath	**Waking from sleep to urinate**	**Leg cramping while sleeping or at rest**
Wheezing	**Vaginal/testicle/penile sores or lumps**	**Difficulty moving arms or legs**
Persistent coughing	**Vaginal or penis discharge**	**Thought of harming yourself**
Waking up short of breath	**Pain with intercourse**	**Recurrent feeling blue or depressed**
Using more pillows to sleep	**Irregular vaginal bleeding**	**Abused by others**
Sleeping in recliner	**Joint pain, stiffness or swelling**	**Feeling cold all the time**
Snoring loudly	**Recurrent back pain**	**Feeling warm all the time**
Not rested when waking up	**Recurrent neck pain**	**Flushing**
Breast pains, lumps or discharge	**Changing moles or skin lesion**	**Loss of hair**
Abdominal pain	**Unusual mole or skin lesion**	**Hair symptoms**
Recurrent nausea or vomiting	**Persistent itching**	**Muscle weakness**
Recurrent heartburn	**Persistent dry skin**	**Decreased sex drive**
Recurrent constipation or diarrhea	**Fainting**	**Urinating more frequently**
Black stools or blood in stool	**Vertigo or dizziness**	**Drinking more water than normal**
Change in stool size	**Numbness or tingling**	**Difficulty with male erection**
Pain when passing bowel movement	**Headaches**	**Bleeding easily**
Bruising easily	**Swollen glands**	

Please list physicians who have contributed to your care		
Specialty	***Year***	***Physician***