MADISON
PRIMARY CARE

Personal / Social Hx – Age 13 to Adult

Patient Name: ______________________________
Drug and Food Allergies and Indicate Reaction: ______________________________
Reason for Today's Visit: ______________________________
Have you ever had a blood transfusion? ☐ Yes ☐ No
Have you had any recent infection, illness or injury? ______________________________
Last doctor: ______________________ Reason for leaving: ______________________
Other doctors/specialists involved in your care: ______________________________

Race / Culture: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Other
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced (# times: ____)
Do you have children? (list genders & ages)______________________________
Where do you live? (house , apartment, nursing home, etc.) ______________________________
Who do you live with? (include all) ______________________________
What activities do you have trouble doing by yourself?
☐ Eating ☐ Dressing ☐ Going to the bathroom ☐ Walking
☐ Bathing ☐ Getting out of bed ☐ Grooming ☐ Communicating
What activities are you NOT able to do? ☐ Manage household ☐ Shopping
☐ Lifting ☐ Cooking ☐ Housecleaning ☐ Laundry
☐ Managing medications ☐ Managing money ☐ Manage home repair ☐ Driving
☐ Use public transportation ☐ Reading ☐ Writing

Current Job/Position: ______________________________
Religious Preference: ______________________________
Do you use tobacco? ☐ Cigarettes ☐ Chewing ☐ Snuff Packs per day _______ Number of years used _______
Were you previously a smoker? ☐ Yes ☐ No If so, year you quit _________ and # of years you smoked ________
Do you live in a house with a smoker? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No Type & Amount: ______________________________
Do you use drugs? ☐ Yes ☐ No If yes, what kind and how often? ______________________________
Do you exercise regularly? ☐ Yes ☐ No If yes, what kind of exercise and how often? ________________
Do you use a seatbelt? ☐ Yes ☐ No Do you use a helmet for biking/skateboarding? ☐ Yes ☐ No ☐ NA
Activities / Hobbies / Sports: ______________________________
Education Completed: ☐ GED ☐ High School ☐ Tech School
☐ College ☐ Post Grad ☐ Other: ______________________
Are you enrolled in: ☐ Public School ☐ Private School ☐ Home school School Grade: ________________
Name of School/ College attending: ______________________________

Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

GENERAL

☐ Fever ☐ Chills ☐ Feeling Tired
☐ Weakness ☐ Weight Loss ☐ Weight Gain

SKIN/HAIR/NAILS/LYMPH

☐ Change in Skin Color ☐ Easy Bruising ☐ Pitted Nails
☐ Dry Skin ☐ Skin Lesions ☐ Mole Changes
☐ Rash ☐ Hair Symptoms ☐ Lesions
☐ Itching ☐ Fingernail Discoloration ☐ Swollen Lymph Nodes

JOINTS/MUSCLES

☐ Muscle Aches ☐ Localized Joint Swelling ☐ Muscle Weakness
☐ Joint Pain, Localized ☐ Localized Joint Stiffness ☐ Muscle Cramps
☐ Gout Attack ☐ Back Pain ☐ Knee Pain
☐ Varicose Veins ☐ Other Pain: ______________________________

ENDOCRINE SYSTEM

☐ Recent Weight Change ☐ Tremors ☐ Excessive Hunger
☐ Temperature Intolerance ☐ Excessive Thirst ☐ Excessive Urination

EYES

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Watery Drainage
- ☐ Mucous-Like Drainage

EARS / NOSE / MOUTH / THROAT

- ☐ Ear Pain
- ☐ Trouble Hearing
- ☐ Ringing in Ears
- ☐ Ear Drainage
- ☐ Sneezing
- ☐ Clear Nasal Drainage
- ☐ Nasal Drainage/Mucous
- ☐ Nasal Stuffiness
- ☐ Nosebleeds
- ☐ Snoring
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Change in Voice
- ☐ Jaw Pain
- ☐ Facial/Sinus Pressure
- ☐ Tooth Ache
- ☐ Bleeding Gums
- ☐ Mouth Sores

BREAST

- ☐ Breast Lump
- ☐ Breast Pain (females)
- ☐ Nipple Discharge (females)

RESPIRATORY SYSTEM

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Night Sweats
- ☐ Exposed to TB
- ☐ Shortness of Breath
- ☐ Trouble Sleeping Flat
- ☐ Coughing Up Sputum

CARDIOVASCULAR SYSTEM

- ☐ Palpitations
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Soft Tissue Swelling

GASTROINTESTINAL SYSTEM

- ☐ Appetite
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Belching
- ☐ Heartburn
- ☐ Flatulence (Gas)
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Stool Changes
- ☐ Bloody Stool
- ☐ Black Stool

GENITOURINARY SYSTEM

- ☐ Decreased Urine Volume
- ☐ Pain during Urination
- ☐ Blood in Urine
- ☐ Changes in Urinary Habits
- ☐ Urinary Loss of Control
- ☐ Birth Control Method: ____________________
- ☐ History of Venereal Disease
- ☐ Sexual Complaints

GENITOURINARY SYSTEM – *Females Only:*

- ☐ Vaginal Discharge
- ☐ Vulvar Itching/Burning
- ☐ Age at first period: __________
- ☐ Abnormal Menses Frequency
- ☐ Abnormal Menses Duration
- ☐ Heavy Bleeding
- ☐ Severe Menstrual Pain
- ☐ Vaginal Dryness
- ☐ Date of last Menstruation: ____________________
- ☐ Age at Menopause: _________
- ☐ Postmenopausal Bleeding

Summary of Previous Pregnancies:

Pregnancies: __________
Full-Term Deliveries: __________
Premature Deliveries: __________
Vaginal Deliveries: _________
C-Section Deliveries: _________
Living Children: _________
Miscarriages: _________
Elective Abortions: _________
Ectopic (Tubal) Pregnancies: _________

GENITOURINARY SYSTEM – *Males Only:*

- ☐ Testicle Symptoms
- ☐ Blood in Semen
- ☐ Abnormal Urethral Discharge
- ☐ Penile Lesion
- ☐ Decreased Urine Flow
- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Frequent Urination at Night

NEUROLOGICAL SYSTEM

- ☐ Sense of Smell Changes
- ☐ Taste Disturbances
- ☐ Difficulty Keeping Balance
- ☐ Difficulty in Speech
- ☐ Abnormality of Walk
- ☐ Increased Sensitivity to Touch / Pain
- ☐ Tingling
- ☐ Numbness
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Confusion
- ☐ Memory Loss
- ☐ Vertigo

PSYCHIATRIC HISTORY

- ☐ Interpersonal Relationship Problems
- ☐ Sleep Disturbances
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Lapses / Loss
- ☐ Hallucinations
- ☐ Thoughts of Hurting Yourself
- ☐ Thoughts of Hurting Someone Else
- ☐ Agitation
- ☐ Restless
- ☐ Sadness

Past Medical Hx

Do you have a **Medical History** of *(check all that apply)*:

☐ Allergic Rhinitis	☐ Chronic Bronchitis	☐ Glaucoma/Eye Disease	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Colitis	☐ Gout	☐ Peptic Ulcer
☐ Anemia	☐ Congestive Heart Failure	☐ Heart Attack	☐ Psychiatric Disorder
☐ Anxiety	☐ COPD	☐ Heartburn/GERD	☐ Renal / Kidney Disease
☐ Arthritis	☐ Crohn's Disease	☐ Heart Disease	☐ Seizure Disorder
☐ Asthma	☐ Dementia	☐ Hepatitis/Liver Disease	☐ Stroke Syndrome
☐ Birth Defects	☐ Depression	☐ High Cholesterol	☐ Substance Abuse
☐ Bleeding Disorder	☐ Diabetes Mellitus	☐ HIV Infection	☐ Thyroid Disorders
☐ Blood Clots	☐ Eczema	☐ Hypertension	☐ Tuberculosis
☐ Breast Lump	☐ Enlarged Prostate	☐ Lung Disease	☐ Other ________
☐ Cancer	☐ Genetic Disease	☐ Migraine Headaches	☐ Other ________

Surgery/Hospitalization

Please list any **Surgeries/Hospitalization** that you have had:

Surgery/Hospitalization/Injury	**Date**
________	________
________	________
________	________
________	________
________	________
________	________
________	________

Family History

Do you have a **FAMILY HISTORY** of *(check all that apply & indicate your relationship to the person affected)*:

☐ Allergic Rhinitis ________	☐ Crohn's Disease ________	☐ Hypertension ________
☐ Alzheimer's Disease ________	☐ Dementia ________	☐ Lung Disease ________
☐ Anemia ________	☐ Depression ________	☐ Migraine Headaches ________
☐ Anxiety ________	☐ Diabetes Mellitus ________	☐ Osteoporosis ________
☐ Arthritis ________	☐ Eczema ________	☐ Peptic Ulcer ________
☐ Asthma ________	☐ Enlarged Prostate ________	☐ Psychiatric Disorder ________
☐ Birth Defects ________	☐ Genetic Disease ________	☐ Renal/Kidney Disease ________
☐ Bleeding Disorder ________	☐ Glaucoma/Eye Disease ________	☐ Seizure Disorder ________
☐ Blood Clots ________	☐ Gout ________	☐ Stroke Syndrome ________
☐ Breast Lump ________	☐ Heart Attack ________	☐ Substance Abuse ________
☐ Cancer/Type:________ ________	☐ Heart Disease ________	☐ Thyroid Disorders ________
☐ Chronic Bronchitis ________	☐ Heartburn/GERD ________	☐ Tuberculosis ________
☐ Colitis ________	☐ Hepatitis/Liver Disease ________	Other: ________ ________
☐ Congestive Heart Failure ________	☐ High Cholesterol ________	Other: ________ ________
☐ COPD ________	☐ HIV Infection ________	

Medications

Please list any **medications** that you are currently taking: Dose/Frequency

Medication	Dose/Frequency

IMM

Last Tetanus shot: ______________________________ Last Flu Vaccine: ________________________________

Last Pneumonia Vaccine: _________________________ Last Chicken Pox Vaccine: _______________________

Last HPV Vaccine: ______________________________ Last Shingles Vaccine: ___________________________

Health Maintenance

Males: *(Indicate the approximate date of your last screening test ________________________________)*

Age 35 and older: Cholesterol level ______________________

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening ___________________

Age 50 or older: Colon Cancer Screening ________________________

Last blood work: ____

Last prostate cancer screening: ________________________________

Last stress test: ____

Last eye exam: ____

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) __________________________

Females: *(Indicate the approximate date of your last screening test ________________________________)*

Age 40 and older: Mammogram ________________________

Age 21-65 or younger and sexually active for 3 years: Pap Test ________________________

Age 45 and older: Cholesterol level _______________________

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density _______________________________

Age 50 or older: Colon Cancer Screening ________________________

Last blood work: ____

Last stress test: ____

Last eye exam: ____

Last dexa scan: ____

Age 25 and younger and sexually active: Chlamydia test ________________________

Other Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) _____________________