

Baptist Primary Care

Your appointment time _____.

Doctor _____ Chart # _____ Date _____

1) Personal Profile

Name _____ Phone: (W) _____ (H) _____

Address _____ Age _____ Birth Date _____

Occupation _____ Marital Status Married Single Divorced

Name of Spouse _____

Name and phone number of person to notify in case of emergency _____

Please list all known allergies to medicines _____

Please list all prescription medications now being used _____

Please list all other medications you are using _____

Are you now using, or have you used birth control pills? Yes No

If yes what type _____ How long have/did you use them _____

Any complications with the pill? Explain _____

Have you ever been pregnant? Yes No How many deliveries _____

Any complications with pregnancies or deliveries? Yes No If yes please explain _____

Date of your last PAP examination _____ Any abnormal PAP _____

Date of your last Mammogram _____ Findings _____

Do you wear a seat belt? Yes No

Do you wear glasses or contact lenses? Yes No Type _____

When was your last eye examination? _____

Do you exercise regularly? Yes No What type? _____

Duration of your exercise _____

Are you regularly exposed to any hazardous chemicals or materials at home or work? Yes No Please list duration of

Daily exposure and type of material(s) _____

What is the reason for this physical examination? _____

Page 2 Patient Name _____ Birth Date _____

When was your last physical examination? _____

Please explain any abnormal findings found at that time _____

How would you describe your health at this time _____

2) Immunization History

Please list dates of your last immunizations (if known)

Tetanus _____

Measles _____

MMR _____

Flu _____

Polio _____

Other _____

Pneumonia _____

3) Family History

For each family member listed, please indicate how their health is. If deceased please indicate the age and cause of death.

Father Age _____

Mother Age _____

Brothers Age _____

Age _____

Age _____

Sisters Age _____

Age _____

Age _____

Do any of your immediate family members now have, or have they had any of the following? Please indicate which member.

Asthma _____

Cancer _____

Diabetes _____

Anemias _____

Ulcers _____

Goiter _____

Seizures _____

Arthritis _____

Tuberculosis _____

Strokes _____

Heart Disease
Or Attack _____

High or Low
Blood Pressure _____

Kidney Stones
Or Disease _____

Hardening of
the Arteries _____

4) Significant Past Medical History

Please list all previous Hospitalizations, Reason, Duration and outcome. _____

Do you now have or have you ever had any of the following?

- | | | | |
|---------------------|--------------------------|-------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | Polio | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Measles (Red) | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | Measles (German) | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Sinusitis | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Broken Bones | <input type="checkbox"/> | Ulcer Disease | <input type="checkbox"/> |
| Anemias | <input type="checkbox"/> | Blood Transfusions | <input type="checkbox"/> |
| Emotional Disorders | <input type="checkbox"/> | High/Low Blood Pressure | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Glandular Disorders | <input type="checkbox"/> |
| Dizzy Spells | <input type="checkbox"/> | Blood in Stool | <input type="checkbox"/> |
| Frequent Headaches | <input type="checkbox"/> | Strokes | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | Changes in a Mole | <input type="checkbox"/> |
| Syphilis | <input type="checkbox"/> | Weight Loss | <input type="checkbox"/> |
| Herpes | <input type="checkbox"/> | Gonorrhea | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Chlamydia | <input type="checkbox"/> |

Have you ever used, or do you now use any Tobacco products Yes No What type _____

For how long? _____ How much do you use each day? _____

Do you drink beverages that contain caffeine? Yes No What type _____

For how long? _____ How much do you use each day? _____

Have you ever used, or do you now use any recreational drugs? Yes No

What type _____ For how long? _____

Page 4 Patient Name _____ **Birth Date** _____

Do you drink alcoholic beverages daily? Yes No What type _____

For how long? _____ How much do you use each day? _____

Have you ever felt you ought to cut down on drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink the first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Please list any additional information about your health, or any special concerns or problems that you may have that you would like to discuss with your Physician at the time of your examination. _____

Patient's Signature

Date

Reviewed by

Date