Santa Cruz
Direct Primary Care

Patient History Form

Name:	DOB:
Partner:	Occupation:

Medications (including prescriptions, non-prescriptions, vitamins and supplements) ☐ No current medications

Allergies to Medications (including latex, or known allergens) ☐No known drug allergies

Surgeries, Hospitalizations, Serious Injuries	Year

Medical History (please check if positive)

	ENT		PULMONARY		GASTROINTESTINAL cont.
	Eye problems		Asthma		Blood in stool
	Allergies/hay fever		Emphysema		Black stool
	Sinus problems		COPD		Hemorrhoids
	Hearing loss		Sleep Apnea		Constipation
			Pneumonia		Diarrhea
	CARDIOVASCULAR		Chronic bronchitis		Hepatitis
	Abnormal EKG		Shortness of breath		Pancreatitis
	Angina				
	Chest pain		GASTROINTESTINAL		GENITOURINARY
	Prior heart attack		Acid Reflux		Chronic urinary infections
	Heart disease		Barrett's esophagitis		Kidney disease
	High blood pressure		History of EGD		Kidney stones
	High cholesterol		Irritable Bowel		Urinary incontinence
	Stroke		Gall bladder problems		Erectile dysfunction
	Peripheral Vascular Disease		Liver disease		Sexually transmitted diseases
	Murmur/heart valve problems		Inflammatory bowel disease		
			Change in bowel habit		

Name:_____ DOB: _____

Medical History Continued

	MUSCULOSKELETAL		HEMATOLOGICAL		SKIN
	Osteoarthritis (joints involved)		Anemia		Eczema
			Bleeding disorders		Psoriasis
			Clotting disorders (DVT history)		Atopic Dermatitis
	Rheumatoid Arthritis		Sickle Cell disease/trait		Melanoma
	Gout		Blood cancers		Squamous cell cancer
	Fibromyalgia		Blood Transfusions (#)		Basal cell cancer
	Muscle disease				
	Spinal disease, stenosis				
			NEUROLOGICAL		PSYCHIATRY
	ENDOCRINE		Chronic Headaches		Depression
	Diabetes		Migraines		Memory Loss
	Thyroid disease		Epilepsy/Seizures		Anxiety
			Radiculopathy		Suicidal thoughts/attempt
			Peripheral Neuropathy		OCD
	OTHER		Concussion		

Gynecological History	OB History
Age periods started:	Number of pregnancies:
Menopause? ☐Yes ☐No If so, at what age:	Number of deliveries:
Regular cycles? ☐Yes ☐No	Miscarriages:
Abnormal pap in the past? ☐Yes ☐No If so, when:	Terminations:
Problems with cycles?	Birth control method:
History of STDs?	

Health Maintenance	Yes	No	Date/Year		Yes	No	Date/Year
Colonoscopy				Bone Density			
Abdominal Ultrasound				Last Eye Exam			
Mammogram				Last Labs			
Pap Smear				Complete Physical Exam			

Immunization History	Yes	No	Date/Year		Yes	No	Date/Year
Pneumovax (pneumonia vaccine)				Hepatitis vaccines ☐A series ☐B series			
Prevnar (new pneumonia vaccine)				Meningitis Vaccine			
Zostavax (Shingles vaccine)				Last MMR (Measles vaccine)			
Last Influenza Vaccine				Gardasil Series (HPV vaccine)			
Tdap (tetanus/whooping cough) Or Td (tetanus) booster				History of Chickenpox or Vaccine			
Last TB (tuberculosis) testing				Other:			

Social History	Yes	No		
Tobacco Use			Packs/day: # of years:	☐ Quit Year:
Alcohol			Drinks per day/week/month:	Type of alcohol:

Name:_____ DOB: _____

Social History Continued	Yes	No	
Caffeine			Type/Cups per day:
Recreational Drugs or history			
Intravenous Drugs or history			
Difficulty with sleep			# of hours per night:
Special Diet			If yes, describe:
Sexually Active			Partner:
Exercise			Describe activity/time/#per week:

Family History

Medical Illness	Mother	Father	Sibling	MGM	MGF	PGM	PGF	Child	Other
Alzheimer's Disease									
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
COPD/Emphysema									
Dementia									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Prostate Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other									

Other Information that we should know: _____
_____
_____
_____
_____

Thank you!

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