FIRST CARE, P.C.

DATE:_____ CHART NO.:_____

NAME: _____AGE:_____SEX:____MARITAL STATUS: S M W D

ADDRESS & ZIP _____TEL: H_____CELL_____W_____

DOB:_____SSN:_____OCCUPATION:_____

HISTORY

FAMILY HISTORY: **Age** **Illnesses** **If deceased, cause of death**

Father_____

Mother_____

Brothers_____

Sisters_____

Children_____

CIRCLE if any family member has one of the following and specify who:

Asthma	Psychiatric disease	High blood pressure
Stroke	Diabetes	Cancer
Liver disease	Heart disease	
Thyroid disease	Kidney disease	

PATIENT'S PAST HISTORY:

Childhood diseases: Measles, Chicken pox, German measles, Mumps, Whooping cough

List medical illnesses: _____

_____

_____

_____

List surgeries & dates: _____

_____

_____

_____

PERSONAL & SOCIAL HISTORY:

Do you smoke? Y N How much?_____ Do you use recreational drugs? Y N List _____

Do you drink alcohol? Y N How much? _____

LIST ANY MEDICATIONS PRESENTLY TAKING (including over the counter meds), DOSE & HOW OFTEN

ALLERGIES:

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SYSTEMS REVIEW

CHECK OR ENCIRCLE IF YOU HAVE ANY OF THE FOLLOWING:

CONSTITUTIONAL: Fever Fatigue Chills Insomnia Wt loss or gain Night sweats

SKIN: Hair loss Rash Itching

HENT: Headaches Colds Sneezing Hearing loss Ear pain Ringing in ears

Nose bleed Sore throat Loss of smell Loss of taste

EYES: Blindness Glasses Blurred vision Irritation Discharge

RESPIRATORY: Cough Bloody sputum Shortness of breath Wheezing

CARDIOVASCULAR: Chest pain Pain in legs Swelling of legs Edema Varicose veins

How many pillows do you sleep on at night under your head? ____ Palpitations

GASTROINTESTINAL: Nausea Vomiting Abdominal Pain Indigestion Loss of appetite

Gas Constipation Diarrhea Bloody stools Hemorrhoids Thirst Problem swallowing

GENITOURINARY: Bloody urine Pain on urination Burning on urination

Do you lose urine when you cough or sneeze? How often do you get up at night to urinate?_____

FOR WOMEN: Date of last period Dysmenorrhea Heavy menses

Irregular period Vaginal discharge Vaginal itching Venereal disease

Problem with intercourse Age at menopause_____ Sexual preference

How many: pregnancies? Children born alive? Stillbirths? Miscarriages? Abortions?

FOR MEN: Sexual preference Impotence Problems with erection Dribbling

Difficulty starting urine Testicular pain Testicular lumps Venereal disease

NEURO: Numbness Paralysis Weakness Dizziness Fainting spells Seizures

PSYCHIATRIC: Anxiety Depression Unusual fears Hallucinations

MUSCULOSKELETAL: Joint pains Leg cramps

_____*DO NOT WRITE BELOW THIS LINE*_____

HISTORY OF PRESENT ILLNESS: