Baptist Primary Care – Durbin Park
550 Durbin Pavilion Drive, Suite G101
St. Johns, FL 32259
Ph: (904) 770.2095 · Fax: (904) 770.2086

Patient name: _____ **Today's date:** _____
Date of birth: _____ **Age:** _____ **Sex: Male** ☐ **Female** ☐
Home phone: _____ **Cell:** _____ **Work:** _____
Emergency contact: _____ **Phone:** _____ **Relationship:** _____

Preferred pharmacy name/phone number: _____
Mail order pharmacy name: _____
Main purpose of your visit today: _____

PAST MEDICAL HISTORY: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below) **OTHER**

☐ No Known Medical Problems
☐ Allergies _____
☐ Asthma/COPD _____
☐ Atrial fibrillation _____
☐ Anxiety _____
☐ Depression _____
☐ Diabetes _____
☐ Cancer (specify type) _____
☐ Gastric reflux _____
☐ Heart disease _____
☐ High cholesterol _____
☐ Hypertension _____
☐ Thyroid disorder _____
☐ TIA/Stroke _____

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

PAST SURGICAL HISTORY: (Indicate Year)

☐ No Prior Surgeries
☐ Appendectomy ____
☐ Bladder surgery ____
☐ Breast surgery ____
☐ Cesarean section _____
☐ Colon resection ____
☐ Gallbladder ____
☐ Hemorrhoid surgery ____
☐ Hernia repair/type _____ (inguinal, femoral, umbilical, hiatal)
☐ Hysterectomy/reason _____ (i.e. fibroids, endometriosis, pain, cancer)
☐ Other: _____
☐ Tonsillectomy ____
☐ Tonsils/Adenoids ____
☐ Transfusion _____
☐ Tubal ligation ____
☐ Vasectomy ____

Other hospitalizations: _____

OBSTETRIC/GYNECOLOGIC HISTORY:

Number of pregnancies _____ Vaginal deliveries _____ Miscarriages _____ Abortions _____
Number of c-sections _____ Last menstrual period _____
Any pregnancy complications (i.e. gestational diabetes, pre-eclampsia) _____
History of sexually transmitted infections? Yes ☐ No ☐ Type/Year _____

FAMILY HISTORY: (Include history of diabetes, heart disease, hypertension, colon, breast, ovarian cancer, other cancers, autoimmune diseases, and age at diagnosis if known)

Relative	**Alive/Deceased**	**Age**	**Health Problems**
Father			
Mother			
Sister			
Brother			
Child			

(Please complete reverse side)

SOCIAL HISTORY:

Marital status: Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐

Children: Yes ☐ No ☐ Ages: _____

Alcohol use: Yes ☐ No ☐ Number of drinks/frequency: _____

Tobacco use: Never ☐ Currently smoke ☐ ____ pack(s) per day for ____ years

Previously smoked ☐ ____ pack(s) per day for ___ years, Quit _____

Chewing tobacco ☐ for ___ years, Quit _____

Caffeine use: None ☐ 1-3 servings/day ☐ 4-6/day ☐ >6/day ☐ Type: _____

Drug use: None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other: _____

Exercise: None ☐ ____ Days per week Type of exercise: _____

Occupation: _____

Ethnic origin: _____

ALLERGIES: ☐ No Known Drug Allergies

Medication/food/environmental allergy	Reaction

CURRENT MEDICATIONS: (Include vitamins, supplements, birth control pills, aspirin, eye drops, etc.)

☐ No Current Medications

Medication name	Dose	Frequency	Refill Needed?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

PREVENTIVE SCREENING:

Last pap smear: _____ History of abnormal pap? Yes ☐ No ☐ When? _____

PCP to perform future paps? Yes ☐ No ☐

Last mammogram: _____ History of abnormal mammogram? Yes ☐ No ☐ Year ____

Last bone density: _____ Findings: Normal ☐ Osteopenia ☐ Osteoporosis ☐ Unsure ☐

Last colonoscopy: _____ Any abnormal findings? _____

Last PSA/Prostate exam: _____ History of abnormal prostate exam? Yes ☐ No ☐

Vaccinations: (Year) Pneumonia _____ Shingles (Zostavax) _____ Tetanus _____ Influenza _____

PREVIOUS PROVIDERS: (Past 5 years)

Name of Provider	Specialty	City/State	Problem seen for	Still Seeing?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐