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 ☐

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

Any complications with the pill? Explain _____

Have you ever been pregnant? ☐ Yes N☐ How many deliveries _____

Any complications with pregnancies or deliveries? ☐ Yes N☐ 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 ☐

Do you wear glasses or contact lenses? ☐ Yes ☐ o Type _____

When was your last eye examination? _____

Do you exercise regularly? ☐ Yes N☐ What type? _____

Duration of your exercise _____

Are you regularly exposed to any hazardous chemicals or materials at home or work? ☐ es N☐ 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:

_____

_____

Page 3 Patient Name _____ Birth Date _____

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

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

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? _____

 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:

_____

_____

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_____ _____

Patient's Signature Date

_____ _____

Reviewed by Date