Personalized Primary Care
General Internal Medicine

Name: ______________________________**DOB**:_____________

Other medical providers' names and contact information:

____

____

Emergency contact name (and relation to patient) and phone #:

____

ALLERGIES:

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY**:**
(OR ATTACH A LIST)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	**PROBLEM/DATE**	**PROBLEM/DATE**

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No If yes did you have any reaction?

HEALTH HABITS

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No
If YES, how many packs per day___________
Do you drink alcohol? ☐ Yes ☐ No
If YES, How many drinks per day? __________Per week?______________
Do you do routine exercise? ☐ Yes ☐ No
What kind?____
How many days per week?____
Do you follow a particular diet? ☐ Yes ☐ No
Describe your diet____

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Partner
Partner's Name:____
Do you think you are at risk for HIV, AIDS or other sexually Transmitted disease? ☐ Yes ☐No
Have you ever been tested for HIV?
If yes, when ____/____. What was the Result? ____
Education: ☐ High School/GED ☐ Vocational School ☐ College ☐ Graduate School
Occupation: ____

Do you have an Advance Directive? ☐ Yes ☐ No

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FAMILY HISTORY	
RELATIVE	HEALTH
FATHER	
MOTHER	
SIBLINGS	
GRANDMOTHER (M)	
GRANDMOTHER (P)	
GRANDFATHER (M)	
GRANDFATHER (P)	
SPECIFIC CONDITIONS:	
1. Alzheimer's Disease ☐ Yes ☐ No ____________	1. Iron Storage Disease ☐ Yes ☐ No ____________
2. Breast Cancer ☐ Yes ☐ No ____________	12. High Blood Pressure ☐ Yes ☐ No ____________
3. Heart Disease ☐ Yes ☐ No ____________	13. Ovarian Cancer ☐ Yes ☐ No ____________
4. Stroke ☐ Yes ☐ No ____________	14. Prostate Cancer ☐ Yes ☐ No ____________
5. Depression, Suicide ☐ Yes ☐ No ____________	15. Skin Cancer ☐ Yes ☐ No ____________
6. Diabetes ☐ Yes ☐ No ____________	16. Thyroid Disease ☐ Yes ☐ No ____________
7. High Cholesterol ☐ Yes ☐ No ____________	17. Sickle Cell Disease ☐ Yes ☐ No ____________
8. Obesity ☐ Yes ☐ No ____________	18. Anemia ☐ Yes ☐ No ____________
9. Glaucoma ☐ Yes ☐ No ____________	19. Macular degeneration ☐ Yes ☐ No ____________
10. Substance Abuse ☐ Yes ☐ No ____________	20.Other:____

HEALTH MAINTENANCE

Last Stools, occult blood test: _____/_____ Colonoscopy/Sigmoidoscopy: _____/_____

Dental Exam: _____/_____ Dilated Eye Exam: _____/_____ Foot Exam: _____/_____

WOMEN: Last: PAP smear: ____/_____ Mammogram: ____/____ Breast Exam: ____/_____

Menstrual Period: ____/____/_____ Bone Density Scan:______/________

MEN: Last: Rectal/Prostate exam: _____/_____ Testicular Exam: _____/_____

PSA:_____/_____

IMMUNIZATIONS: (last date/year received)

Tetanus: __________

Hepatitis B vaccine: __________ MMR: _________

Shingles: __________ HPV: _________

Flu: __________ Other: _________

Pneumonia: __________ _________

____

Tuberculosis Skin Test (date & results) _____________

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iPPC Personalized Primary Care
General Internal Medicine

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

CONSTITUTIONAl

Symptom	Yes	No
Unexplained weight loss	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No

Eyes

Symptom	Yes	No
Cataract	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No

ENMT

Symptom	Yes	No
Bleeding from gums	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No
Change in your voice	☐ Yes	☐ No
Denture	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Mouth ulcers	☐ Yes	☐ No

CARDIOVASCULAR

Symptom	Yes	No
Angina	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No

RESPIRATORY

Symptom	Yes	No
Bronchitis	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

SKIN

Symptom	Yes	No
Skin changes	☐ Yes	☐ No
Skin lesions	☐ Yes	☐ No
Skin itching	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No

GASTROINTESTINAL

Symptom	Yes	No
Blood in stool	☐ Yes	☐ No
Change in movements	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Black tarry stool	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No

GENITOURINARY

Symptom	Yes	No
Problems urinating	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Hernias	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Urination at night	☐ Yes	☐ No
Sexual transmitted Dz.	☐ Yes	☐ No
Urinary urgency	☐ Yes	☐ No

WOMEN ONLY

Symptom	Yes	No
Problems with your period	☐ Yes	☐ No
Vaginal dryness	☐ Yes	☐ No
Problems with sex	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Pain in breast	☐ Yes	☐ No
Lumps in breast	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

MEN ONLY

Symptom	Yes	No
Problems with erections	☐ Yes	☐ No
Dribbling of urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Pain in testicles	☐ Yes	☐ No

MUSCULAR SKELETAL

Symptom	Yes	No
Neck pain	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Injury to limbs	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Joint stiffness	☐ Yes	☐ No
Locking joints	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Red or Swollen in joints	☐ Yes	☐ No

HEMATOLOGY/ONCOLOGY

Symptom	Yes	No
Anemia or low blood	☐ Yes	☐ No
Easily bruise	☐ Yes	☐ No
Swollen lymph nodes	☐ Yes	☐ No
Cancers	☐ Yes	☐ No

PSYCHIATRIC

Symptom	Yes	No
Depression or Sadness	☐ Yes	☐ No
Feel like hurting someone	☐ Yes	☐ No
Feel like hurting yourself	☐ Yes	☐ No
Problems with memory	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Problems concentrating	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No

NEUROLOGY

Symptom	Yes	No
Change in memory	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Imbalance	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

ENDOCRINE

Symptom	Yes	No
Problems with heat	☐ Yes	☐ No
Problems with cold	☐ Yes	☐ No
Swelling in neck	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Changes in hair	☐ Yes	☐ No

Problems that I would like to discuss:

Patient Signature:____ **Date:**__________________________

Reviewed by:____ **Date:**__________________________

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