



# PrimeCare Medical Center

"Our Emphasis is on Quality Healthcare"

Patrick E. Evivie, MD, FACP  
Medical Director

Hans Kwaku, MD

Kim Neely, PA-C

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>NAME</b> ( <i>Last, First, M.I.</i> ):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>PREVIOUS OR REFERRING DOCTOR:</b>		<b>DATE OF LAST PHYSICAL EXAM:</b>	

### PERSONAL HEALTH HISTORY

<b>CHIEF COMPLAINT:</b>			
Location			
Duration			
Does anything make the problem worse?		Is the problem constant or variable?	

### LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

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### SURGERIES AND OR HOSPITALIZATIONS

Year	Reason	Hospital

### HAVE YOU EVER HAD A BLOOD TRANSFUSION?

Yes  No

### ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

### HEALTH HABITS AND PERSONAL SAFETY

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Internal Medicine, Diabetes Resource Center and Urgent Care

[www.primecaremed.org](http://www.primecaremed.org)

Phone: 704-335-0806/ Fax: 704-334-2073



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	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>FATHER</b>			<b>SIBLING</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>MOTHER</b>				<input type="checkbox"/> M <input type="checkbox"/> F	

## MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you satisfied with life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in: <input type="checkbox"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Ability to sleep <input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

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