**Primary Health Group - Appomattox**
*HCA Virginia Health System*

LAST NAME _____ FIRST NAME _____ MI _____ AGE _____ DOB _____
ADDRESS _____
PHONE _____ RACE _____ SEX _____

ALLERGIES & REACTION THAT OCCURED: _____

CURRENT MEDICATIONS:

| NAME | STRENGTH | DOSAGE | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

MEDICAL ILLNESS (CHECK CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

| | | | |
|---|---|---|---|
| _____ALCOHOLISM | _____COPD/EMPHYSEMA | _____HEPATITIS | _____PROSTATE PROBLEM |
| _____ANEMIA | _____DEPRESSION | _____HERPES | _____STROKE |
| _____ANXIETY | _____DIABETES | _____HIGH CHOLESTEROL | _____HYPOTHYROIDISM |
| _____ARTHRITIS | _____GOUT | _____KIDNEY DISEASE | _____ULCER DISEASE |
| _____ASTHMA | _____HEART DISEASE | _____LIVER DISEASE | _____SLEEP APNEA |
| _____CANCER | _____HIGH BLOOD PRESSURE | _____MIGRAINE | _____OTHER _____ |

PREVIOUS HOSPITALIZATIONS (INCLUDING SURGERY)

| DATE | REASON FOR HOSPITALIZATION OR TYPE OF SURGERY |
|---|---|
| | |
| | |
| | |
| | |
| | |

FAMILY HISTORY
FATHER'S AGE _____ /OR AGE AT DEATH _____ CAUSE OF DEATH _____
HEALTH PROBLEMS _____

MOTHER'S AGE _____ /OR AGE AT DEATH _____ CAUSE OF DEATH _____
HEALTH PROBLEMS _____

NUMBER OF SIBLINGS: _____
HEALTH PROBLEMS: _____

PLEASE CIRCLE IF ANY RELATIVES HAVE HAD THE FOLLOWING:

HEART BYPASS or STENTS STROKE HEART ATTACK COLON CANCER
PROSTATE CANCER OVARIAN CANCER BREAST CANCER DETAILS: _____

SOCIAL HISTORY
MARITAL STATUS(CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

CHILDREN _____ BOYS _____ GIRLS _____

HEALTH PROBLEMS _____

YOUR OCCUPATION _____
WHO DO YOU LIVE WITH? _____

HAVE YOU EVER SMOKED YES NO IF YES, PACK(S) PER DAY _____ HOW MANY YEARS _____ QUIT DATE _____

DO YOU DRINK ALCOHOL? YES NO DRINKS PER OCCASION _____ DRINKS PER WEEK _____

HAVE YOU EVER USED ILLICIT DRUGS (COCAINE, MARIJUANA, ETC) YES NO
REMARKS: _____

Primary Health Group - Appomattox
HCA Virginia Health System

# Review of Systems

Check symptoms you currently or recently have had

GENERAL
- ☐ YES ☐ NO FEVER
- ☐ YES ☐ NO WEIGHT LOSS
- ☐ YES ☐ NO WEIGHT GAIN
- ☐ YES ☐ NO FATIGUE

ENT
- ☐ YES ☐ NO BLURRED VISION
- ☐ YES ☐ NO EAR PAIN
- ☐ YES ☐ NO HOARSENESS
- ☐ YES ☐ NO LOSS OF HEARING
- ☐ YES ☐ NO NOSE BLEED
- ☐ YES ☐ NO RINGING IN EARS
- ☐ YES ☐ NO RUNNY NOSE
- ☐ YES ☐ NO SORE THROAT
- ☐ YES ☐ NO SNORING
- ☐ YES ☐ NO STOP BREATHING DURING SLEEP

PULMONARY
- ☐ YES ☐ NO COUGH
- ☐ YES ☐ NO COUGHING UP BLOOD
- ☐ YES ☐ NO SHORTNESS OF BREATH
- ☐ YES ☐ NO WHEEZING

CARDIOVASCULAR
- ☐ YES ☐ NO CALF PAIN WITH WALKING
- ☐ YES ☐ NO CHEST PAIN
- ☐ YES ☐ NO IRREGULAR HEART BEAT
- ☐ YES ☐ NO PALPITATIONS
- ☐ YES ☐ NO SWELLING OF ANKLES

GASTROINTESTINAL
- ☐ YES ☐ NO BLACK, TARRY STOOLS
- ☐ YES ☐ NO BLOATING/GAS
- ☐ YES ☐ NO BLOOD IN STOOL
- ☐ YES ☐ NO BOWEL CHANGES
- ☐ YES ☐ NO CONSTIPATION
- ☐ YES ☐ NO DIARRHEA
- ☐ YES ☐ NO EXCESSIVE HUNGER
- ☐ YES ☐ NO HEMORRHOIDS
- ☐ YES ☐ NO INDIGESTION LOSS OF APPETITE (HEARTBURN)
- ☐ YES ☐ NO NAUSEA
- ☐ YES ☐ NO STOMACH PAIN
- ☐ YES ☐ NO VOMITING

GENITO-URINARY
- ☐ YES ☐ NO BLOOD IN URINE
- ☐ YES ☐ NO FREQUENT URINATION
- ☐ YES ☐ NO INCONTINENCE
- ☐ YES ☐ NO PAINFUL URINATION

MUSCULOSKELATAL
- ☐ YES ☐ NO PAIN ☐ WHERE
- ☐ YES ☐ NO SWELLING ☐ WHERE
- ☐ YES ☐ NO WEAKNESS ☐ WHERE

NEUROLOGICAL
- ☐ YES ☐ NO DIZZINESS
- ☐ YES ☐ NO HEADACHE
- ☐ YES ☐ NO MEMORY LOSS
- ☐ YES ☐ NO NUMBNESS ☐ WHERE
- ☐ YES ☐ NO TINGLING ☐ WHERE
- ☐ YES ☐ NO WEAKNESS ☐ WHERE

PSYCHOLOGICAL
- ☐ YES ☐ NO DEPRESSION
- ☐ YES ☐ NO ANXIETY
- ☐ YES ☐ NO PANIC ATTACKS
- ☐ YES ☐ NO THOUGHTS OF HURTING YOURSELF

SKIN
- ☐ YES ☐ NO HIVES
- ☐ YES ☐ NO ITCHING
- ☐ YES ☐ NO CHANGE IN MOLES
- ☐ YES ☐ NO RASH
- ☐ YES ☐ NO SORES THAT WON'T HEAL

MEN ONLY
- ☐ YES ☐ NO BREAST LUMP
- ☐ YES ☐ NO ERECTION DIFFICULTIES
- ☐ YES ☐ NO LUMP IN TESTICLES
- ☐ YES ☐ NO PENIS DISCHARGE
- ☐ YES ☐ NO SORE ON PENIS
- ☐ YES ☐ NO DATE OF LAST PHYSICAL _____

WOMEN ONLY
- ☐ YES ☐ NO ABNORMAL PAP
- ☐ YES ☐ NO BREAST LUMP
- ☐ YES ☐ NO HOT FLASHES
- ☐ YES ☐ NO IRREGULAR PERIODS
- ☐ YES ☐ NO NIPPLE DISCHARGE
- ☐ YES ☐ NO PAINFUL INTERCOURSE
- ☐ YES ☐ NO PAINFUL PERIODS
- ☐ YES ☐ NO VAGINAL DISCHARGE

Date of last Pap Smear _____
Date of last Mammogram _____
Date of last period _____
Number of Pregnancies _____ Births _____
Are you pregnant now? Yes No

Date of last Colonoscopy: _____