OWENSVILLE PRIMARY CARE
HISTORY & PHYSICAL

Name _____ **Date of Birth** _____

Address _____ **Home Phone #** _____

_____ **Work Phone #** _____

Social Security # _____ **Occupation** _____ **Cell Phone #** _____

HOSPITALIZATION/SURGERY

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS

Hepatitis B	YES	NO	When _____
Pneumovax	YES	NO	When _____
Flu	YES	NO	When _____
Tetanus	YES	NO	When _____

DRUG ALLERGIES

_____

_____

_____

MEDICATION LIST

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

MEDICAL HISTORY

____	Ringing in Ear	____	Bloody or Tarry Stools	____	Nervousness
____	Ear Infections-Frequent	____	Hemorrhoids	____	Depression
____	Dizziness/Fainting	____	Hernia	____	Memory Loss
____	Failing Vision	____	Urine Infections-Frequent	____	Moodiness-Excessive
____	Eye Infections	____	Blood in Urine	____	Phobias
____	Nose Bleeds	____	Kidney Stones	____	Mental Illness
____	Sinus Trouble	____	Venereal Disease	____	Lactose Intolerance
____	Sore Throats-Frequent	____	Urethral Discharge	____	Prostate Disease
____	Hayfever/Allergies	____	Chronic Fatigue	____	Sexual Menstruation Dysfunction
____	Pneumonia	____	Weight Loss-Recent	____	Frequent Infections
____	Bronchitis/Chronic Cough	____	Anemia	____	Diphtheria
____	Asthma/Wheezing	____	Bruise Easily	____	Tetanus
____	Chest Pain	____	Cancer	____	Chicken Pox
____	High Blood Pressure	____	Diabetes	____	Polio
____	Heart Murmur	____	Thyroid Disease	____	Mumps
____	Swollen Ankles	____	Convulsions/Seizures	____	Measles
____	Leg Pain- walking	____	Stroke	____	Rubella
____	Varicose Veins/Phlebitis	____	Tremor/Hands Shaking	____	Rheumatic Fever
____	Loss of Appetite	____	Muscle Weakness	____	Scarlet Fever
____	Difficulty Swallowing	____	Numbness/Tingling Sensations	____	Tuberculosis
____	Indigestion or Heartburn	____	Headaches-Frequent	____	Herpes
____	Persistent Nausea/Vomiting	____	Arthritis/Rheumatism		**URINATION**
____	Peptic Ulcers	____	Osteoporosis	____	Overnight > than twice
____	Abdominal Pain-Chronic	____	Back Pain-Recurrent	____	Painful
____	Gall Bladder Trouble	____	Bone Fracture/Joint Injury	____	Loss of Control
____	Jaundice/Hepatitis	____	Gout	____	Decrease in Force/Flow
____	Change in Bowel Habits	____	Foot Pain		
____	Diarrhea	____	Cold Numb Feet	____	Other _____
____	Constipation	____	Rashes/Hives	____	Other _____
____	Diverticulosis	____	Psoriasis	____	Other _____
____	Crohn's/Colitits	____	Eczema	____	Other _____

PLEASE TURN FORM OVER

OWENSVILLE PRIMARY CARE
HISTORY & PHYSICAL

FEMALES (Please Complete)

Pregnant	YES	NO	Menstrual Flow:	____	Regular	Days of Flow	_____
Planning Pregnancy	YES	NO		____	Irregular	Length of Cycle	_____
Pain/Bleeding during or after sex	YES	NO		____	Pain/Cramps		

Number of:
_____ Pregnancies
_____ Miscarriages
_____ Abortions
_____ Live Births

Birth Control Method _____
Name of Birth Control Pill _____

Do you have your Well Woman Exam (PAP and Breast Exam) done at Owensville Primary Care? ***Yes*** ***No***

Are you:	Test	Provider/Organization Name	Date Last Done
21 yrs or older (females only)	**Pap Smear**		/ /
40 yrs or older (females only)	**Mammogram**		/ /
50 yrs or older (female & male)	**Colonoscopy**		/ /

FAMILY HISTORY
Has any member of your family (including parents, grandparents, and siblings) ever had the following?

	Which Family Members	Approx. when Diagnosed
Alcoholism		
Asthma		
Bleeding Disorder		
Cancer		
Diabetes		
Glaucoma		
Epilepsy/Convulsions		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Mental Illness		
Migraine		
Osteoporosis		
Stroke		
Thyroid Disease		
Other _____		
Other _____		

HABITS

____ Alcohol Type _____ Amount _____ How Long _____
____ Smoke Daily Qty _____ How Long _____
____ Coffee Cups Daily _____

PREVENTION

Do you wear seatbelts?	YES	NO	If no, why not?	_____
Do you wear a bike helmet?	YES	NO	N/A	
Do you have a working smoke detector?	YES	NO	N/A	
If there is a gun in your home, is it out of children's reach and unloaded?	YES	NO		
Do you wish to be tested for AIDS?	YES	NO		
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	YES	NO	If yes, explain	_____