HHC PhysiciansCare, Inc.

HHC PhysiciansCare, Inc. Preventive Visit History Form

Last Name: ______________________ First Name: __________________ DOB: __________ Age: __________

Date of service: ___________________

Present Occupation: ___________________ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered

List household members (name/age): ____

List any Allergies to medicines, foods, insects, etc. with reaction: ______________________________

____

Lifestyle Review:

Please list approximate date of your last:

Dental exam: __________ Eye Exam: __________ Any problems with hearing? __________

Are you on any special kind of diet? __________ If so, what kind? ________________

Do you feel you eat a healthy diet? __________

Do you have any weight concerns? __________

Do you exercise? __________ How often? __________ What type? __________

Do you use tobacco products now or did you smoke in the past? ☐ Yes ☐ No If yes, what type? __________

How many/day ______? How many years ______? Age stopped _______?

About how much alcohol do you have on an average day? __________ or week? __________

Do you sometimes use street drugs (cocaine, marijuana, heroin, etc)? __________

Reproductive Health and Cancer Screening:

Men:

Are you sexually active? __________

How many partners in the past 5 years? __________

Men, women, or both? __________

Do you use birth control/contraception? __________

If yes, what type? __________

Do you have problems with sex or intercourse? _____

When was your last prostate screening?

PSA: __________ Exam: __________

Do you examine your testicles for lumps? __________

Date of last colonoscopy: __________

Women:

When was your last menstrual period? __________

Do you have any problems with periods? __________

Are you sexually active? __________

How many partners in the past 5 years? __________

Men, women, or both? __________

Do you use birth control/contraception? __________

If yes, what type? __________

Number of pregnancies __________

Number of births __________

Date of last pap smear __________

Date of last mammogram __________

Do you check your breast for lumps? __________

Date of last colonoscopy? __________

Date of last bone density test? __________

Risk Screening:

Question	Response
Do you always wear seatbelts in a car?	☐ Yes ☐ No
Do you wear helmets when appropriate?	☐ Yes ☐ No
Do you wear sunscreen when appropriate?	☐ Yes ☐ No
Do you have working smoke and carbon monoxide detectors?	☐ Yes ☐ No
Do you have any unsecured firearms in your home?	☐ Yes ☐ No
Do you have any history of abuse or violence in your home?	☐ Yes ☐ No
Do you have problems with stress or anger management?	☐ Yes ☐ No
Have you had driving violations?	☐ Yes ☐ No
Do you have concerns about your memory?	☐ Yes ☐ No
Do you have any work or travel exposures or risks?	☐ Yes ☐ No

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Date of service:__________

IF YOU HAVE HAD A PHYSICAL OR PREVENTIVE EXAM WITH HHC PhysiciansCare, Inc. IN THE PAST, PLEASE ONLY RECORD ANY UPDATES OR CHANGES TO YOUR MEDICAL HISTORY IN THIS SECTION.

Immunizations

Date of last tetanus shot? __________ Has it been more than 10 years? ❒ Yes ❒ No

If you're over 65, have you had the pneumonia shot (pneumovax)? ❒ Yes ❒ No

Do you get an annual "Flu" (Influenza) vaccine? ❒ Yes ❒ No

Have you been exposed to Tuberculosis or had a positive TB test in the past? ❒ Yes ❒ No

Have you ever had chicken pox or shingles? ❒ Yes ❒ No **If yes, when?** __________

Have you had the Hepatitis B vaccine? ❒ Yes ❒ No **If yes, when?** __________

Have you had the HPV (Gardasil) vaccine? ❒ Yes ❒ No **If yes, when?** __________

If you're over 60, have you had the shingles vaccine? ❒ Yes ❒ No

Medical History:

CURRENT MEDICINES: List all medications- include hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, supplements, and over the counter medicines ❒ Check here if none

NAME OF MEDICATION	MILLIGRAMS	TIMES PER DAY	NAME OF MEDICATION	MILLIGRAMS	TIMES PER DAY

Medical Conditions – Check all that apply now or in the past:

❒ Alcohol or drug problem	❒ Ear problems	❒ Lyme disease
❒ Allergies / Hay fever	❒ Gallbladder problem	❒ Radiation treatment
❒ Anemia	❒ Headaches / Numbness	❒ Seizures/ Epilepsy
❒ Arthritis / Gout	❒ Heart Trouble/Angina/Heart murmur	❒ Sexually transmitted disease
❒ Blood clots / Phlebitis	❒ Hepatitis	❒ Sleep Apnea/ Sleep problems
❒ Cancer / Tumor	❒ High cholesterol	❒ Skin Cancer/ Rashes
❒ Colon / Bowel problem	❒ High blood pressure	❒ Stomach or Duodenal ulcer/Heartburn
❒ Depression / Anxiety	❒ Kidney problems/ Kidney stones	❒ Stroke
❒ Diabetes	❒ Liver disease	❒ Thyroid
❒ Dizziness	❒ Lung problems/ Asthma	❒ Urinary/prostate/Sexual problems
❒ Abnormal mammogram or pap		

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List any specialists you see on a regular basis:

LIST ALL HOSPITALIZATIONS, OPERATIONS (INCLUDING CHILDHOOD), SERIOUS INJURIES, AND ILLNESSES SINCE YOUR LAST PHYSICAL EXAM AT HHC PhysiciansCare, Inc.

	YEAR		YEAR

Family History:

If your mother (m), father (f), sister (s), brother (b) or children (c) have any
Please list which relative has had the medical problem

❐ I don't know my family medical history ❐ I am adopted

	Family member		*Family member*		*Family member*
❐ Alcohol/drug problem		❐High Blood Pressure		❐ Prostate cancer	
❐ Breast Cancer		❐ High cholesterol		❐ Sickle cell anemia	
❐ Colon cancer/polyps		❐Mental illness/depression		❐ Skin cancer	
❐ Diabetes		❐ Suicide		❐ Thyroid problem	
❐ Heart problems		❐ Osteoporosis		❐ Other Cancer	
❐ Other		❐ Other		❐ Other	