

LYNCH PRIMARY CARE

CONCIERGE MEDICINE



Medical History (Major or Chronic Illness)

Approx. Year of Onset	Diagnosis

Surgical History

Year	Type of Operation

MEDICATIONS - Prescription/OTC/Herbal

Allergies

Drug	Reaction

Immunizations

Type	Year
Tetanus	
Flu (seasonal)	
Pneumonia	
Zoster (Shingles)	

Patient Name

DOB

Date

Social History

Habits:

Tobacco Use (How much, how long?) _____

Alcohol Use (Average Daily Use) _____

Caffeine Products (Average Daily Use) _____

Drug History (Which drugs, how long?) _____

	Yes	No	Comments
Diet:			
General Healthy	<input type="radio"/>	<input type="radio"/>	_____
Eat Out > 1 x weekly	<input type="radio"/>	<input type="radio"/>	_____
Fast Food > 1 x weekly	<input type="radio"/>	<input type="radio"/>	_____
I have Issues	<input type="radio"/>	<input type="radio"/>	_____

Exercise (How often, what type?) _____

Hobbies: _____

Marital Status: _____ How many years: _____ Currently reside with: _____

Number of Children: _____ Age of Children: _____

Present Occupation (Include hours per week): _____

Career History (If retired): _____

Year Retired (If Applicable): _____ Education (Highest Year or Degree Obtained): _____

Religious Affiliation: _____

Miscellaneous: _____

Patient Name

DOB

Date

Family History

	Age (If living)	Age (At time of death)	Cause of Death
Mother			
Father			
Brother / Sister <i>(circle one)</i>			
Brother / Sister <i>(circle one)</i>			
Brother / Sister <i>(circle one)</i>			
Brother / Sister <i>(circle one)</i>			
Brother / Sister <i>(circle one)</i>			

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name _____

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Review of Systems

Circle symptoms or problems which apply to you. If there are any terms that are not clear, please ask the doctor to explain at the time of your exam. Please place an "X" in the circle provided beside the category if none of the symptoms apply to you.

General Health: Weight at Age of 18 _____, Maximum Weight _____ Recent Weight Change; Fatigue; Loss of Appetite; Fever; Chills; Night Sweats Describe your health (circle one): Excellent, Fair, Poor, Failing <input type="radio"/>	
Dermatologic: Skin Cancers; Psoriasis; Seborrhea; Hives; Recurring rashes <input type="radio"/>	
Head, Ears, Eyes, Nose, Throat: Head Injury; Nose Bleeds; Recurrent sinus infections; Seasonal Allergies; Glaucoma; Cataracts; Unusual Visual Disturbances; Ringing in Ears; Dizziness; Swallowing Disorders; Hoarseness; Gum Disease Date of Last Eye Exam: _____ Date of Last Dental Exam: _____ <input type="radio"/>	
Pulmonary: Pneumonia; Asthma; Tuberculosis; Chronic Cough; Cough up Blood; Positive TB Skin Test or TB Exposure; Shortness of Breath Date of Last Chest X-ray: _____ <input type="radio"/>	
Cardiac: History of Rheumatic Fever; Murmur; Chest Pain; Heart Attack; Swelling of Legs; Irregular or Skipped Heart Beats; Inability to Lie Flat (because of shortness of breath). Last EKG: _____ <input type="radio"/>	
Vascular: History of Hypertension (High Blood Pressure); Leg Pains When Walking; Clots; Aneurysm <input type="radio"/>	
Gastrointestinal: Indigestion/Hiatal Hernia; Peptic Ulcer Disease; Hepatitis; Gallbladder Disease; Pancreatitis, Diarrhea; Constipation; Rectal Bleeding; Recurrent Nausea or Vomiting; Food Intolerance; Change in Bowel Habits Date of Last Colonoscopy: _____ <input type="radio"/>	
Musculoskeletal: Pain; Stiffness or Swelling of Joint; Fractures; Back Aches; Disc Syndrome Date of Last DEXA Scan: _____ <input type="radio"/>	
Genitourinary: Recurrent Bladder or Kidney infections; Kidney Stones; Prostate Disorder; Incontinence; Frequent Urination; Urination at Night; Blood in Urine <input type="radio"/>	
Gynecological: Abnormal PAP Smears; Breast Disorder Number of Pregnancies: _____ Number of Miscarriages: _____ Month/Year Last Menstrual Period: _____ <input type="radio"/> Name of Gynecologist: _____ Date of Last PAP Smear: _____ Date of Last Mammogram: _____	
Endocrine: Diabetes; Thyroid Disorder; High Cholesterol or Triglycerides <input type="radio"/>	
Hematology: Anemia; Easy Bruising; Bleeding Disorder; History of Transfusions <input type="radio"/>	
Neurology: Seizures; Convulsions or Epilepsy; Fainting Spells; Stroke; Ministroke; Recurrent Headaches; Memory Impairments; Numbness or Weakness <input type="radio"/>	
Psychiatric: Stress; Depression; Anxiety; Mood Swings; Hallucinations; Suicide History <input type="radio"/>	
Sleep: Difficulty Falling Asleep; Difficult Staying Asleep; Early morning Awakening; Snoring; Day-time Drowsiness; Sleep Apnea <input type="radio"/>	

Patient Name

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