PPC Personalized Primary Care
General Internal Medicine

Name: _____**DOB**:_____

Other medical providers' names and contact information:

_____

_____

Emergency contact name (and relation to patient) and phone #:

_____

ALLERGIES:

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY**:**
(OR ATTACH A LIST)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No If yes did you have any reaction?

HEALTH HABITS

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No
If YES, how many packs per day_____
Do you drink alcohol? ☐ Yes ☐ No
If YES, How many drinks per day? _____Per week?_____
Do you do routine exercise? ☐ Yes ☐ No
What kind?_____
How many days per week?_____
Do you follow a particular diet? ☐ Yes ☐ No
Describe your diet_____

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Partner
Partner's Name:_____
Do you think you are at risk for HIV, AIDS or other sexually Transmitted disease? ☐ Yes ☐ No
Have you ever been tested for HIV?
If yes, when ____/____. What was the Result? ____
Education: ☐ High School/GED ☐ Vocational School ☐ College ☐ Graduate School
Occupation: _____

Do you have an Advance Directive? ☐ Yes ☐ No

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FAMILY HISTORY	
RELATIVE	HEALTH
FATHER	
MOTHER	
SIBLINGS	
GRANDMOTHER (M)	
GRANDMOTHER (P)	
GRANDFATHER (M)	
GRANDFATHER (P)	

SPECIFIC CONDITIONS:					
1. Alzheimer's Disease	☐ Yes	☐ No _____	1. Iron Storage Disease	☐ Yes	☐ No _____
2. Breast Cancer	☐ Yes	☐ No _____	12. High Blood Pressure	☐ Yes	☐ No _____
3. Heart Disease	☐ Yes	☐ No _____	13. Ovarian Cancer	☐ Yes	☐ No _____
4. Stroke	☐ Yes	☐ No _____	14. Prostate Cancer	☐ Yes	☐ No _____
5. Depression, Suicide	☐ Yes	☐ No _____	15. Skin Cancer	☐ Yes	☐ No _____
6. Diabetes	☐ Yes	☐ No _____	16. Thyroid Disease	☐ Yes	☐ No _____
7. High Cholesterol	☐ Yes	☐ No _____	17. Sickle Cell Disease	☐ Yes	☐ No _____
8. Obesity	☐ Yes	☐ No _____	18. Anemia	☐ Yes	☐ No _____
9. Glaucoma	☐ Yes	☐ No _____	19. Macular degeneration	☐ Yes	☐ No _____
10. Substance Abuse	☐ Yes	☐ No _____	20.Other:_____		

HEALTH MAINTENANCE

Last Stools, occult blood test: _____/_____ Colonoscopy/Sigmoidoscopy: _____/_____

Dental Exam: _____/_____ Dilated Eye Exam: _____/_____ Foot Exam: _____/_____

WOMEN: Last: PAP smear: ____/_____ Mammogram: ____/____ Breast Exam: ____/_____

Menstrual Period: ____/____/_____ Bone Density Scan:_____/_____

MEN: Last: Rectal/Prostate exam: _____/_____ Testicular Exam: _____/_____

PSA:_____/_____

IMMUNIZATIONS: (last date/year received)

Tetanus: _____
Hepatitis B vaccine: _____
Shingles: _____
Flu: _____
Pneumonia: _____

MMR: _____
HPV: _____
Other: _____
_____
_____

Tuberculosis Skin Test (date & results) _____

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Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

CONSTITUTIONAl			**SKIN**			**MUSCULAR SKELETAL**		
Unexplained weight loss	☐ Yes	☐ No	Skin changes	☐ Yes	☐ No	Neck pain	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No	Skin lesions	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Fevers	☐ Yes	☐ No	Skin itching	☐ Yes	☐ No	Injury to limbs	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Rashes	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Dry skin	☐ Yes	☐ No	Joint stiffness	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No	**GASTROINTESTINAL**			Locking joints	☐ Yes	☐ No
Eyes			Blood in stool	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Cataract	☐ Yes	☐ No	Change in movements	☐ Yes	☐ No	Red or Swollen in joints	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	**HEMATOLOGY/ONCOLOGY**		
Glasses	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Anemia or low blood	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No	Difficulty swallowing	☐ Yes	☐ No	Easily bruise	☐ Yes	☐ No
ENMT			Heart burn	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No
Bleeding from gums	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No	Cancers	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No	Black tarry stool	☐ Yes	☐ No	**PSYCHIATRIC**		
Change in your voice	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No	Depression or Sadness	☐ Yes	☐ No
Denture	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No	Feel like hurting someone	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	**GENITOURINARY**			Feel like hurting yourself	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No	Problems urinating	☐ Yes	☐ No	Problems with memory	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No	Hernias	☐ Yes	☐ No	Problems concentrating	☐ Yes	☐ No
Mouth ulcers	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Problems sleeping	☐ Yes	☐ No
CARDIOVASCULAR			Urination at night	☐ Yes	☐ No	**NEUROLOGY**		
Angina	☐ Yes	☐ No	Sexual transmitted Dz.	☐ Yes	☐ No	Change in memory	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Urinary urgency	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	**WOMEN ONLY**			Headaches	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No	Problems with your period	☐ Yes	☐ No	Imbalance	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No	Vaginal dryness	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No	Problems with sex	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No	Vaginal discharge	☐ Yes	☐ No	Tremors	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No	Pain in breast	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No	Lumps in breast	☐ Yes	☐ No	**ENDOCRINE**		
RESPIRATORY			Breast discharge	☐ Yes	☐ No	Problems with heat	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	**MEN ONLY**			Problems with cold	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Problems with erections	☐ Yes	☐ No	Swelling in neck	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No	Dribbling of urine	☐ Yes	☐ No	Frequent urination	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Weak urine stream	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Pain in testicles	☐ Yes	☐ No	Changes in hair	☐ Yes	☐ No

Problems that I would like to discuss:

Patient Signature:_____ **Date:**_____

Reviewed by:_____ **Date:**_____

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