FULLER PRIMARY CARE PLLC

Please fill out this medical history form and bring it with you to your physical exam. Date of Exam

FAMILY HISTORY If any blood relative has suffered any of the following, please indicate which relative.

☐Allergy_____	☐Epilepsy_____	☐Hypertension_____	☐Stroke_____
☐Arthritis_____	☐Glaucoma_____	☐Kidney Disease_____	☐Tuberculosis_____
☐Cancer_____	☐Gout_____	☐Mental Illness_____	☐Other (specify)_____
☐Diabetes_____	☐Heart Attack_____	☐Migraine_____	_____

PAST HISTORY

Date	Significant Illness or Operation	Date	Significant Illness or Operation

IMMUNIZATION (approx. date of last inj.) **CURRENT MEDS** **DRUG ALLERGY**

☐Diphtheria_____			
☐Tetanus_____			
☐Flu_____			
☐Pneumovax_____			

MEDICAL HISTORY (circle the box for current problems, check the box and give your approx. age for past symptoms or diseases)

MAIN PROBLEMS 1)_____ 2)_____ 3)_____

☐Decreased hearing	☐Difficulty swallowing	☐Anemia ☐Bruise easily	☐Measles ☐German measles
☐Ringing in ear	☐Indigestion or heartburn	☐Cancer	☐Rhumatic ☐Scarlet fever
☐Ear infections - frequent	☐Persistent nausea / vomiting	☐Diabetes	☐Mumps ☐Tuberculosis
☐Dizzy spells	☐Peptic ulcers	☐Thyroid disease	☐Alcohol ____ drinks per week
☐Failing vision	☐Abdominal pain -chronic	☐Convulsions / Seizures	☐Smoking ____ cigarettes per day
☐Double or blurred vision	☐Change in bowel hapits - recent	☐Stroke	☐Drug use / abuse _____ type
☐Eye pain	☐Diarrhea ☐Constipation	☐Tremor / hands shaking	☐Coffee / tea ____ cups per day
☐Eye Infections - frequent	☐Diverticulosis	☐Muscle Weakness	**Females - Menstrual History**
☐Hay fever / allergies	☐Bloody or tarry stools	☐Numbness / tingling sensations	Age of onset____ ☐Reg. ☐Irreg.
☐Hoarseness - prolonged	☐Hemorrhoids	☐Headaches - frequent	Flow: ☐Heavy ☐Medium ☐Light
☐Pneumonia / pleurisy	☐Gall bladder trouble	☐Arthritis / rheumatism	☐Pain / cramps with menstrual flow
☐Bronchitis / chronic cough	☐Jaundice / hepatitis	☐Back pain - recurrent	Days of flow_____
☐Asthma / wheezing	☐Hernia	☐Bone fracture / joint injury	Length of cycle_____
☐Shortness of breath	☐Urine infections - frequent	☐Gout	☐Pain / bleeding after sex
☐On Exertion ☐Lying flat	☐Painful urination	☐Foot pain ☐Cold numb feet	Number of pregnancies_____
☐Chest Pain	☐Blood in urine	☐Rashes ☐Eczema	Number of live births_____
☐High blood pressure	☐Overnight urination - more than 2	☐Psoriasis ☐Hives	Number of miscarriages_____
☐Palpitations	☐Control in urination	☐Sleeping - difficulty	Birth control method_____
☐Irregular Pulse	☐Decrease in force of urination	☐Nervousness ☐Depression	B.C. pill name_____
☐Swollen ankles	☐Kidney stones	☐Memory loss	☐Flushing / menopausal symptoms
☐Fainting spells	☐Venereal disease	☐Moodiness - excessive	**Other symptoms or diseases:**
☐Leg pain when walking	☐Urethral discharge	☐Phobias	_____
☐Varicose veins / phlebitis	☐Chronic fatigue	☐Mental illness	_____
☐Loss of appetite - recent	☐Weight loss - frequent	☐Chickenpox ☐Polio	_____

SYNPOSIS **(Do NOT write in the space below)**

A:
P:

Signature:_____