Patient Centered Care, PLL-C

1221 Floral Parkway Unit 105.
Wilmington, NC 28403

HEALTH HISTORY

NAME_____ AGE _____ D.O.B._____

SYMPTOMS: Check symptoms you are having or have had in the past year

GENERAL
____CHILLS
____DEPRESSION
____DIZZINESS
____FAINTING
____FEVER
____FORGETFULNESS
____HEADACHE
____LOSS OF SLEEP
____LOSS OF WEIGHT
____NERVOUSNESS
____NUMBNESS
____TINGLING

MUSCLE/JOINT/BONE PAIN, WEAKNESS, NUMBNESS
____ARMS
____BACK
____FEET
____HANDS
____HIPS
____LEGS
____NECK
____SHOULDERS

GENITO-URINARY
____BLOOD IN URINE
____FREQUENCY
____LACK OF BLADDER CONTROL
____PAINFUL URINATION

RESPIRATORY
___SOB/DYSPNEA
___OXYGEN

GASTROINTESTINAL
____POOR APPETITE
____EXCESSIVE HUNGER
____BLOATING
____BOWEL CHANGES
____CONSTIPATION
____DIARRHEA
____GAS
____HEMORRHOIDS
____RECTAL BLEEDING
____INDIGESTION
____NAUSEA
____VOMITING
____VOMITING BLOOD
____STOMACH PAIN

CARDIOVASCULAR
____CHEST PAIN
____HIGH BLOOD PRESSURE
____IRREGULAR HEART BEAT
____LOW BLOOD PRESSURE
____POOR CIRCULATION
____RAPID HEART BEAT
____SWELLING OF ANKLES
____VARICOSE VEINS

SKIN
____BRUISE EASILY
____HIVES
____ITCHING
____CHANGE IN MOLES
____RASH
____SCARS
____NONHEALING SORE

EYE, EAR, NOSE, THROAT
____BLEEDING GUMS
____BLURRED VISION
____CROSSED EYES
____DIFFICULTY SWALLOWING
____DOUBLE VISION
____EARACHE
____EAR DISCHARGE
____HAY FEVER
____HOARSENESS
____LOSS OF HEARING
____NOSEBLEEDS
____PERSISTENT COUGH
____RINGING IN EARS
____SINUS PROBLEM
____VISION – FLASHES
____VISION – HALOS

MOBILITY
____CANE
____WALKER
____WHEELCHAIR

MEN ONLY
____BREAST LUMP
____ERECTION DIFFICULTIES
____PENILE DISCHARGE
____SORE ON PENIS
____VASECTOMY
____OTHER

WOMEN ONLY
____BREAST LUMP
____HOT FLASHES
____HYSTERECTOMY
____NIPPLE DISCHARGE
____OOPHERECTOMY
____ABNORMAL PAP
____MENSTRUAL PAIN
____PAINFUL INTERCOURSE
____VAGINAL DISCHARGE
____ABNORMAL BLEEDING
____OTHER

NUMBER OF PREGNANCIES
_____

NUMBER OF LIVE BIRTHS
_____

DATE OF MAMMOGRAM
_____

DATE OF PAP SMEAR
_____

DATE OF ONSET MENOPAUSE
_____

DATE OF LAST PHYSICAL
_____

NAME_____

CONDITIONS Check conditions you have or have had in the past.

____AIDS	____CHEMICAL ABUSE	____HIGH CHOLESTEROL	____PROSTATE PROBLEMS
____ALCOHOLISM	____CHICKEN POX	____HIV POSITIVE	____PSYCHIATRIC CARE
____ANEMIA	____DIABETES	____KIDNEY DISEASE	____RHEUMATIC FEVER
____ANOREXIA	____EMPHYSEMA	____LIVER DISEASE	____SCARLET FEVER
____APPENDICITIS	____EPILEPSY	____MEASLES	____STROKE
____ARTHRITIS	____GLAUCOMA	____MIGRAINES	____SUICIDE ATTEMPT
____ASTHMA	____COITER	____MISCARRIAGES	____THYROID PROBLEMS
____BLEEDING DISORDER	____GONORRHEA	____MONONUCLEOISIS	____TONSILLITIS
____BREAST LUMP	____GOUT	____MULTIPLE SCLEROSIS	____TUBERCULOSIS
____BRONCHITIS	____HEART DISEASE	____MUMPS	____TYPHOID FEVER
____BULIMIA	____HEPATITIS	____PACEMAKER	____ULCERS
____CANCER	____HERNIA	____PNEUMONIA	____VAGINAL NFECTIONS
____CATARACTS	____HERPES	____POLIO	____VENEREAL DISEASE

MEDICATIONS List medications you are currently taking. Include over the counter medications.

_____

_____

_____

ALLERGIES List all allergies to medication or food _____

_____

_____

NAME & PHONE NUMBER OF YOUR PHARMACY_____

WHY ARE YOU HERE TODAY?_____

_____

FAMILY HISTORY Fill in health information about your family.

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	CHECK IF YOUR BLOOD RELATIVES HAD: DISEASE	RELATION

Father						Arthritis	
Mother						Asthma	
Brothers						Cancer	
						Chemical Abuse	
						Diabetes	
						Heart Disease	
Sisters						High blood pressure	
						Kidney disease	
						Tuberculosis	

HOSPITALIZATIONS			PREGNANCY HISTORY	
Year	Hospital	Reason for Hospitalization	Year/Sex	Complications, if any
			HEALTH HABITS	

HAVE YOU HAD A BLOOD TRANSFUSION?		WHEN?	Caffeine, cups daily	
SERIOUS ILLNESS/INJURIES	DATE	OUTCOME	Tobacco	
			Age started	
			Age stopped	
			Pack per day	
			Recreational Drugs	
			Type	

CONCERNS Check if you are exposed to the following				Alcohol	
	Stress, emotional		Abuse, Physical	Age started	
	Stress, physical		Abuse, Emotional	Age stopped	
	Stress, financial		Heavy Lifting	Ounces daily	
	Family illness		Hazardous substances	Type	
	Abuse, chemical		Occupation:		

I certify that the above information is correct tot the best of my knowledge. I will not hold my provider or any member of her staff responsible for errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

NAME_____

DIRECTIONS: PLEASE CIRCLE 1 IN EACH ROW. CHOOSE THE 1 THAT BEST DESCRIBES YOU.

AREA OF CONCERN	1	2	3	4	5	6
PAIN	NONE	OCCASIONALLY NO MEDICATION	OFTEN NEED PAIN MEDICATION	ALWAYS USE MEDICATIONS ON A REGULAR SCHEDULE	SEVERE, USE MEDICATION; PAIN LIMITS ACTIVITY	UNBEARABLE, NO RELIEF
SHORTNESS OF BREATH	NONE	OCCASIONALLY AFTER EXERCISE, LIFTING GROCERY TRANSPORTATION	REGULARLY AFTER EXERCISE, LIFTING GOCERIES, WALKING	PULMONARY, CARDIAC DIAGNOSIS, WITH REGULAR MEDICATION	MODERATE, LIMITS DAILY ACTIVITY	SEVERELY LIMITS DAILY ACTIVITIES, USE OF OXYGEN
PRESCRIBED MEDICATION	NONE	ONE OR TWO	THREE OR FOUR	FIVE OR SIX	SEVEN OR MORE	HAVE HAD AN ADVERSE REACTION
MEDICATION: OVER THE COUNTER	NONE	ONE OR TWO	THREE OR FOUR	FIVE OR SIX	SEVEN OR EIGHT	HAVE HAD AN ADVERSE REACTION
NUTRITION	NO PROBLEM	I AM ON A SPECIAL DIET	I DO NOT EAT 3 MEALS DAILY	I FEEL OVER-WEIGHT FOR MY FRAME	I FEEL UNDER-WEIGHT FOR MY FRAME	MY APPETITE IS POOR
URINATION	NO PROBLEM	FREQUENT URINATION, BURNING, DRIBBLING	INCREASED URINATION AT NIGHT, HOW MANY TIMES AT NIGHT	INCONTINENT, LOSE URINE BEFORE GETTING TO THE BATHROOM	I WEAR A PROTECTIVE GARMENT	I WEAR A URINARY CATHETER

NAME_____

AREA OF CONCERN	1	2	3	4	5	6
BOWEL MOVEMENT	DAILY	EVERY 2 DAYS	EVERY 3 DAYS	USE LAXATIVES REGULARLY	DIARRHEA OR CONSTIPATION (CIRCLE ONE)	LOSE CONTROL
COGNITION	MEMORY ACCURATE	OCCASIONALLY FORGET	FREQUENTLY FORGET	FOGETING RECENT EVENTS	FORGET PAST EVENTS	EPISODES OF GETTING LOST
EMOTION	I COPE WELL	I SOMETIMES FEEL NERVOUS, TENSE, LONELY, FEARFUL, WORRISOME	I SOMETIMES FEEL DEPRESSED, I HAVE TROUBLE SLEEPING	I FEEL I MAY HAVE A DRINKING PROBLEM	I FEEL HOPELESS, DEPRESSED, HAVE NO ENERGY, I AM LOSING WEIGHT, AM NOT SLEEPING WELL	
MOBILITY	INDEPENDENT	I DO NOT DRIVE, BUT USE PUBLIC TRANSPORT	CANE, WALKER, CRUTCHES, UNASSISTED IN HOME AND COMMUNITY	UP MOST OF THE DAY IN CHAIR, REQUIRE A CANE OR WALKER	IN BED MOST OF THE DAY, NEED ASSISTANCE TO GET UP, USE WHELCHAIR, CANE OR WALKER	BED BOUND, USE LIFT, NEED FULL ASSISTANCE
SELF CARE	INDEPENDENT	NEED HELP WITH HOUSEHOLD CHORES	NEED HELP WITH SHOPPING, MEAL PREPARATION, HOUSEKEEPING	NEED HELP WITH BATHING, DRESSING	REQUIRE HELP WITH BATHING, DRESSING, TOILET, MEALS AND HOUSEKEEPING	NEED HELP WITH ALL ACTIVITY OF DAILY LIVING, MUST BE FED
HEALTH RATING	1 EXCELLENT	2	3	4	5	6 POOR