PORTSMOUTH CITY HEALTH DEPARTMENT

PRIMARY CARE HISTORY

PATIENT NAME _____**PHARMACY**_____**DOB** _____**AGE:**_____

PAST OR PRESENT ILLNESS (circle all that apply):

☐NONE

Diabetes Asthma Hepatitis Cancer

Heart Disease Thyroid Disorder Anemia

Liver Disease Kidney Disease Blood Clotting Disorder

Depression/Anxiety High Blood Pressure

High Cholesterol Seizure Disorder

MAJOR OPERATIONS (SURGERY & YEAR):

☐NONE

_____

_____

MEDICATION(S):

Medication Allergies: ☐NONE ☐SEE LIST

_____

Current Medications & Prescribing Doctor: ☐NONE

_____

_____

_____

_____

LIFESTYLE/RISK FACTORS:

Alcohol?

☐ Less than 2 beers per day

☐ More than 2 beers per day ☐ None

Condom Use? ☐ No ☐ Occasionally ☐ Yes

Diet? ☐Balanced ☐ Overeating ☐ Undereating

Drug Use? ☐Heroin ☐Inhaled ☐Marijuana ☐Other(s) ☐Downers ☐Uppers ☐ None

Physical Activity/Exercise?

☐Mild Exercise ☐Occasional Vigorous Exercise

☐Regular Vigorous Exercise ☐Sedentary (no exercise)

Are you currently sexually active? ☐ Yes ☐ No

Number of Partners in the last year? _____

Have you ever had a Sexually Transmitted infection?

☐ Yes ☐ No

If so, what? ☐ Chlamydia ☐ Trichomonas ☐Herpes ☐ Gonorrhea ☐ Syphilis ☐ HIV

Tobacco Use?

☐ Current User: Packs per day _____

☐ Decreasing Tobacco ☐ Never ☐ Recently Quit

FAMILY HISTORY:

Relative (Mother, Father, Brother, Sister, etc.)	Diagnosis	Age of Diagnosis (if available)