CONNECTIONS PRIMARY CARE

2721 Shoreline Drive, Suite 120
Denton, TX. 76210
Phone: 940-205-6584
Fax: 940-324-0633

Website: www.ConnectionsPrimaryCare.com

Patient Information Form

PERSONAL HISTORY – Please check past or current history for the following health issues:

Current	Past	Condition
GENERAL HEALTH		
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Unexpected weight loss / weight gain
EYES		
☐	☐	Blurred / Double vision
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Itchiness / Dry eyes / Pain in eyes
HEAD / NECK		
☐	☐	Hay fever (pollen allergy)
☐	☐	Hearing loss / Fullness in ears
☐	☐	Ear / Neck / Sinus pain
☐	☐	Sinusitis / Congestion
CARDIOVASCULAR		
☐	☐	Coronary Artery Disease
☐	☐	Circulation Problems
☐	☐	Congestive Heart Failure
☐	☐	Arrhythmias (irregular heart beat)
☐	☐	Heart Murmur / Valve issues
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Defibrillator / Pacemaker
☐	☐	Heart Attack / Angina (chest pain)
RESPIRATORY		
☐	☐	Asthma / COPD / Emphysema
☐	☐	Pneumonia / Bronchitis
☐	☐	Shortness of Breath / Persistent cough
☐	☐	TB (active / latent / prior exposure)
☐	☐	Blood in sputum (spit)
☐	☐	Positive TB skin test
BREAST		
☐	☐	Abnormal mammogram
☐	☐	Discharge from nipple(s) / unhealed sores
☐	☐	Breast lumps / puckered skin / biopsies
GENITAL / REPRODUCTIVE		
☐	☐	Abnormal Pap Smear (cervical dysplasia)
☐	☐	Genital / anal warts
☐	☐	infertility
☐	☐	STI (herpes, gonorrhea, chlamydia, syphilis)
MUSCULOSKELETAL		
☐	☐	Joint Pain / Swelling / Stiffness / Arthritis
☐	☐	Fracture:
☐	☐	Muscle aches / muscle stiffness
☐	☐	Osteopenia / Osteoporosis

Current	Past	Condition
NEUROLOGICAL		
☐	☐	Headaches: Tension / Cluster / Migraine / Sinus
☐	☐	Seizure disorder
☐	☐	Dizziness / Stroke
PSYCHIATRIC		
☐	☐	ADD / ADHD
☐	☐	Anxiety / Depression / Panic Disorder / PTSD
☐	☐	Disordered eating: Anorexia / Bulimia / Mixed
☐	☐	Insomnia / Hypersomnia / Hyposomnia
☐	☐	Substance Abuse: Drugs / Alcohol / Other:
GASTROINTESTINAL		
☐	☐	Diarrhea / Constipation / Urgency / Incontinence
☐	☐	Diverticulosis / Diverticulitis
☐	☐	Crohns / Colitis / Irritable Bowel Syndrome (IBS)
☐	☐	Abnormal stool: bloody / mucous / greasy
☐	☐	Hemorrhoids / Polyps
☐	☐	Hernia
☐	☐	Hepatitis / Jaundice
☐	☐	Abdominal Pain / Bloating / Gas
☐	☐	Liver disease / fatty liver
☐	☐	Heartburn / gastric ulcer
URINARY		
☐	☐	Incontinence (loss of bladder control): Urge / Stress
☐	☐	Kidney disease / Dark colored urine
☐	☐	Urinary frequency / urgency / pain
☐	☐	Bloody urine / Foul smelling urine
☐	☐	Slow urine stream / dribbling
☐	☐	Enlarged Prostate (MEN)
SKIN & LYMPH		
☐	☐	Eczema / Rash / Open Sores / Cracked skin
☐	☐	Swelling around lymph nodes
ENDOCRINE		
☐	☐	Thyroid dysfunction
☐	☐	Cold / Heat Intolerance
☐	☐	Diabetes / Excessive thirst
HEME / ONC / IMMUNOLOGY		
☐	☐	Cancer:
☐	☐	Anemia / Clotting disorder / bleed or bruise easily
☐	☐	Sickle Cell Anemia
☐	☐	HIV / AIDS
☐	☐	Blood Transfusion (year):
☐	☐	Auto-immune disorder
☐	☐	Other:

Patient Name: _____ Date: _____

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HEALTH MAINTENANCE:

Cholesterol testing:	Total Cholesterol:	LDL:	HDL:	Triglycerides:
Vaccination dates:	Influenza:	Tetanus:	Pneumovax:	
Bone Densitometry:				
Colonoscopy:		Fecal Slide:		
Cardiac Stress Test:		Echocardiogram		EKG:
FOR MEN:	PSA:		Rectal Exam:	
FOR WOMEN:	Mammogram:		Pap Smear:	

MEDICAL CONDITIONS – Any issues that require(d) medications or ongoing evaluation by healthcare provider(s):

Condition	Date Diagnosed (year)	Type of treatment received (ex. Medication, chemo, surgery, therapy, hospitalization)	Date Resolved (year)

SOCIAL HISTORY:

Occupation:		
Do you exercise regularly?	☐ **Yes** ☐ **No**	**Type of exercise:** **How often?** **How many minutes per session?**
Do you drink alcohol?	☐ **Yes** ☐ **No**	**How much?** **How often?** **What do you drink?**
Do you drink caffeinated beverages?	☐ **Yes** ☐ **No**	**Coffee / Tea / Soda / Other:** **How much?** **How often?**
Do you smoke?	☐ **Yes** ☐ **No**	**When did you start smoking (age)?** **How much?**
Former smoker?	☐ **Yes** ☐ **No**	**Age when you started?** **Age when you quit?** **How much?**
Do you use recreational drugs?	☐ **Yes** ☐ **No**	**Current / Past** **What?** **How often?**

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FAMILY HISTORY:

Relative	Medical Issue	Is Relative Deceased?	If yes, age at time of death?
ex. Mother	High blood pressure	☐ Yes ☒ No	N/A
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

SURGICAL / PROCEDURE HISTORY:

Date of Surgery / Procedure	Type of Surgery / Procedure

MEDICATIONS – Please include over-the-counter, herbals, supplements, and vitamins:

Medication	Dose	Route	Frequency	How long have you taken?

ALLERGIES:

Medications / Foods / Environmental	Reactions

Patient Name: _____ Date: _____