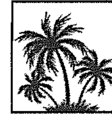

Palmetto Tri-County Primary Care
201-A West Meeting Street
Lancaster, SC 29720
803-286-4666 / FAX: 803-285-1585

Medical History

Date ______________________

Name ______________________ Age __________ Birthdate ______________
Address ______________________ Sex ☐ Male ☐ Female
______________________ Home Phone ______________________
______________________ Work Phone ______________________
Occupation ______________________ Emergency Contact ______________________
Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name ______________________
Children's names and ages ______________________

Allergies to Medications, X-ray Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list name of medicine and type of reaction)

____

Past Medical History and Review of Systems
Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Skin diseases
☐ Heart Disease	☐ T.B.	☐ Gall Bladder disease	☐ Blood disorders
☐ Chest pain/chest tightness	☐ Hay fever	☐ Colitis	☐ Venereal diseases
☐ Shortness of breath	☐ Abdominal discomfort	☐ Hepatitis or jaundice	☐ Anxiety
☐ Swollen ankles	☐ Indigestion	☐ Thyroid disease	☐ Depression
☐ Palpitations	☐ Nausea	☐ Head or neck radiation	☐ Anemia
☐ Lightheadedness	☐ Vomiting	☐ Headache	☐ Alcohol abuse
☐ Frequent urination	☐ Constipation	☐ Kidney disease	☐ Drug abuse
☐ Rheumatic fever	☐ Diarrhea	☐ Kidney stones	☐ Gout
☐ Asthma	☐ Blood in stool	☐ Difficulty urinating	☐ Impotence or Erectile Dysfunction
	☐ Ulcers		☐ Other

____

Gynecologic and Obstetric History

Age at onset of periods __________ Frequency __________ Length of period __________
Pregnancies __________ Births __________ Miscarriages __________
Prolonged or abnormal bleeding ☐ No ☐ Yes (Please describe) __________
Leakage of urine ☐ No ☐ Yes (Please describe) __________
Pelvic pain ☐ No ☐ Yes (Please describe) __________
Abnormal discharge ☐ No ☐ Yes (Please describe) __________
History of abnormal Pap smear ☐ No ☐ Yes (Please describe) __________

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

Medical History

Name ______________________ **Date** ____________

Please List and Supply the Dates of:

Operations ____________ ____________ ____________

____________ ____________ ____________

Hospitalizations other than for surgery ____________ ____________

____________ ____________ ____________

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? __________

_Other? ☐ No ☐ Yes When? __________

Pneumovax immunization? ☐ No ☐ Yes When? __________

Flu immunization? ☐ No ☐ Yes When? __________

Tetanus immunization? ☐ No ☐ Yes When? __________

When was your last:

Pap Smear?__________ Breast Exam?__________ Colon Cancer Test? __________

Mammogram? __________ Cholesterol check?__________ Prostate exam?__________

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other ____________		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts? ☐ Yes ☐ No If no, why not? __________

Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A

Do you exercise regularly? ☐ Yes ☐ No If yes, type, duration and number of times per week? __________

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day?__________

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week? __________

Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day? __________

Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day? __________

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ Yes ☐ No ☐ N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: __________

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: __________

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain: __________

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes ☐ N/A

Do you have a "living will"? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Method of birth control?__________

This information is for use by your physician as part of your confidential medical record.