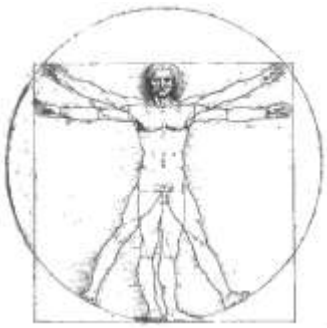

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Primary Care of Shelton, LLC

Name: _____ DOB: _____

Your email address:

Your preferred pharmacy:

Your preferred imaging center:

Occupation: _____

ALLERGIES: -

_____

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE, INCLUDING VITAMINS AND SUPPLEMENTS) INCLUDE NAME, DOSAGE & FREQUENCY**:**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	PROBLEM/DATE

PERSONAL & SOCIAL HISTORY

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If, yes answer questions below.

Do you use any street drugs or abuse prescription pain medication? ☐ Yes ☐ No

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SOCIAL HISTORY: SHORT DESCRIPTION OF JOB, MARITAL STATUS AND LIVING CONDITION:

Have you ever been tested for HIV? ☐ Yes ☐ No

If yes, when ____/____. What was the Result? ____

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		☐ Alive ☐ Deceased		
Mother		☐ Alive ☐ Deceased		
1. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
2. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		

FAMILY HISTORY			RELATIVE				RELATIVE
1. Alzheimer's Disease	☐ Yes	☐ No	_____	11. Iron Storage Disease	☐ Yes	☐ No	_____
2. Breast Cancer	☐ Yes	☐ No	_____	12. High Blood Pressure	☐ Yes	☐ No	_____
3. Heart Disease	☐ Yes	☐ No	_____	13. Ovarian Cancer	☐ Yes	☐ No	_____
4. Stroke	☐ Yes	☐ No	_____	14. Prostate Cancer	☐ Yes	☐ No	_____
5. Depression, Suicide	☐ Yes	☐ No	_____	15. Skin Cancer	☐ Yes	☐ No	_____
6. Diabetes	☐ Yes	☐ No	_____	16. Thyroid Disease	☐ Yes	☐ No	_____
7. High Cholesterol	☐ Yes	☐ No	_____	17. Sickle Cell Disease	☐ Yes	☐ No	_____
8. Obesity	☐ Yes	☐ No	_____	18. Anemia	☐ Yes	☐ No	_____
9. Glaucoma	☐ Yes	☐ No	_____	19. Macular degeneration	☐ Yes	☐ No	_____
10. Substance Abuse	☐ Yes	☐ No	_____	20. Other:			_____

HEALTH MAINTENANCE; Last Stools, occult blood test: _____/_____ Colonoscopy/Sigmoidoscopy: _____/_____

Dental Exam: _____/_____ Dilated Eye Exam: _____/_____ Foot Exam: _____/_____

WOMEN: Last: PAP smear: ____/_____ Mammogram: ____/____ Breast Exam: ____/_____ Menstrual Period: ____/____/_____

MEN: Last: Rectal/Prostate exam: _____/_____ Testicular Exam: _____/_____ PSA: _____/_____

IMMUNIZATIONS: (last date/year received):Tetanus: _____ Hepatitis B vaccine: _____MMR:_____
Pneumonia: _____ Flu: _____ Tuberculosis Skin Test (date & results): _____

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months. Check "No" box if you do not.

CONSTITUTIONAl			SKIN			MUSCULAR SKELETAL		
Unexplained weight loss	☐ Yes	☐ No	Skin changes	☐ Yes	☐ No	Neck pain	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No	Skin lesions	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Fevers	☐ Yes	☐ No	Skin itching	☐ Yes	☐ No	Injury to limbs	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Rashes	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Dry skin	☐ Yes	☐ No	Joint stiffness	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No	GASTROINTESTINAL			Locking joints	☐ Yes	☐ No
Eyes			Blood in stool	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Cataract	☐ Yes	☐ No	Change in movements	☐ Yes	☐ No	Red or Swollen in joints	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	HEMATOLOGY/ONCOLOGY		
Glasses	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Anemia or low blood	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No	Difficulty swallowing	☐ Yes	☐ No	Easily bruise	☐ Yes	☐ No
ENMT			Heart burn	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No
Bleeding from gums	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No	Cancers	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No	Black tarry stool	☐ Yes	☐ No	PSYCHIATRIC		
Change in your voice	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No	Depression or Sadness	☐ Yes	☐ No
Denture	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No	Feel like hurting someone	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	GENITOURINARY			Feel like hurting yourself	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No	Problems urinating	☐ Yes	☐ No	Problems with memory	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No	Hernias	☐ Yes	☐ No	Problems concentrating	☐ Yes	☐ No
Mouth ulcers	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Problems sleeping	☐ Yes	☐ No
CARDIOVASCULAR			Urination at night	☐ Yes	☐ No	NEUROLOGY		
Angina	☐ Yes	☐ No	Sexual transmitted Dz.	☐ Yes	☐ No	Change in memory	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Urinary urgency	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	WOMEN ONLY			Headaches	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No	Problems with your period	☐ Yes	☐ No	Imbalance	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No	Vaginal dryness	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No	Problems with sex	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No	Vaginal discharge	☐ Yes	☐ No	Tremors	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No	Pain in breast	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No	Lumps in breast	☐ Yes	☐ No	ENDOCRINE		
RESPIRATORY			Breast discharge	☐ Yes	☐ No	Problems with heat	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	MEN ONLY			Problems with cold	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Problems with erections	☐ Yes	☐ No	Swelling in neck	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No	Dribbling of urine	☐ Yes	☐ No	Frequent urination	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Weak urine stream	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Pain in testicles	☐ Yes	☐ No	Changes in hair	☐ Yes	☐ No

Patient's Signature: _____ Date: _____