PCS PRIMARY CARE SPECIALISTS™

3109 Walnut Grove Road
Memphis, TN 38111
901-458-0162

PATIENT MEDICAL HISTORY

Patient Name: **Patient Name** DOB: **Date of Birth** Date: Report Date
Pharmacy/Cross Streets: Pharmacy Phone Number:

ALLERGIES
Please list all **allergies** including medicines and food.

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____

Why are you seeing the doctor today? ______________________________

FAMILY HISTORY

Has any member of **your family** (including your parents, grandparents and siblings) ever had the following medical conditions?

Cancer	☐ Yes ☐ NO	Glaucoma	☐ YES ☐ NO
Hypertension	☐ YES ☐ NO	Bleeding Diseases	☐ YES ☐ NO
Heart Attack	☐ YES ☐ NO	Heart Disease	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Other	☐ YES ☐ NO
Stroke	☐ YES ☐ NO		
Mental Illness	☐ YES ☐ NO		
Drug Problems	☐ YES ☐ NO		
Alcohol Abuse	☐ YES ☐ NO		

If you answered YES to any of the above, please state the relationship and give a brief explanation below:

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CURRENT COMPLAINTS (Review of Systems)

Please answer YES or NO if **you have had** any of the following conditions:

		Lightheadedness	☐ YES ☐ NO
Headache	☐ YES ☐ NO	Frequent Urination	☐ YES ☐ NO
Vision changes	☐ YES ☐ NO	Painful urination	☐ YES ☐ NO
Sore throat	☐ YES ☐ NO	Missed period	☐ YES ☐ NO
Chest pain or tightness	☐ YES ☐ NO	Decreased fetal movement	☐ YES ☐ NO
Shortness of Breath	☐ YES ☐ NO	Swollen glands	☐ YES ☐ NO
Swollen Ankles	☐ YES ☐ NO	Persistent cough	☐ YES ☐ NO
Palpitations	☐ YES ☐ NO	Rash	☐ YES ☐ NO
Ear pain	☐ YES ☐ NO	Abdominal Discomfort	☐ YES ☐ NO

Please answer YES or NO if **you are currently** experiencing any of the following conditions:

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Indigestion	☐ YES	☐ NO	Unexplained wt gain	☐ YES	☐ NO
Nausea	☐ YES	☐ NO	Unexplained wt loss	☐ YES	☐ NO
Vomiting	☐ YES	☐ NO	Rectal pain	☐ YES	☐ NO
Constipation	☐ YES	☐ NO	Abnormal vaginal discharge	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO	Penile discharge	☐ YES	☐ NO
Blood in stool	☐ YES	☐ NO	Easy bruising	☐ YES	☐ NO
Ulcers	☐ YES	☐ NO	Colic	☐ YES	☐ NO
Change in bowel patterns	☐ YES	☐ NO	Decreased urination, diaper count	☐ YES	☐ NO
Headaches	☐ YES	☐ NO	Breast mass	☐ YES	☐ NO
Decreased hearing	☐ YES	☐ NO	Low Back Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO	Excess sadness	☐ YES	☐ NO
Difficult urinating	☐ YES	☐ NO	Difficulty sleeping	☐ YES	☐ NO
Heat or cold intolerance	☐ YES	☐ NO	Anxiety	☐ YES	☐ NO
Change in alcohol intake	☐ YES	☐ NO	Fatigue	☐ YES	☐ NO
Joint Pain	☐ YES	☐ NO	Heartburn	☐ YES	☐ NO
Numbness	☐ YES	☐ NO	Weakness of limb	☐ YES	☐ NO

Smoking status: ☐ never smoked ☐ smoker in past and stopped ☐ currently smoke

If you answered YES to any of the above, please explain below:

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____

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MEDICAL AND SURGICAL HISTORY (DATES)

Last MAMMOGRAM______________________ Last PAP ______________________

Last COLONOSCOPY ______________________ Last PSA ______________________

Last EYE EXAM ______________________

OTHER/SURGERIES______________________ ______________________

______________________ ______________________

______________________ ______________________

CURRENT MEDICATIONS AND DOSAGES

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Thank you for your assistance.

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