PRIMARY MEDICAL CARE HEALTH SERVICES PERIODIC EXAM HISTORY

Since your last examination, have you had or been diagnosed with any of the following?
If YES, please explain in the space provided or on the back of this form

PROBLEM	YES	PROBLEM	YES	PROBLEM	YES
Chest pain or Pressure		Unintentional Weight Gain/Loss		Hoarseness	
Irregular Heart Beat		Kidney Problems		Eczema	
Shortness of Breath		Blood in Urine		Skin rash or itching	
Heart Trouble		Frequent/Painful Urination		Hives	
High Blood Pressure		Venereal Disease		Sores that Do Not Heal	
Stroke		Fertility Problems		Easy Bruising	
Varicose Veins		Back or Neck Problems/Injury		Diabetes	
Recurrent Cough		Arthritis		Thyroid Trouble	
Coughing Blood		Bursitis		Recurrent Fever	
Chronic Bronchitis		Pain/Swelling of Joints		Frequent Infections	
Pneumonia		Muscle Strains		Swollen Glands	
Emphysema		Broken Bones		Measles	
Asthma/Wheezing		Head Injury		Malaria	
Hay Fever		Frequent Headaches		Amenia/Blood Disease	
Abnormal Chest X-ray		Dizzy Spells		Cancer or Tumor	
Tuberculosis		Seizures or Fits		Breast Lump/Discharge	
Ankle Swelling		Paralysis		Hernia (Rupture)	
Severe Abdominal Pain		Numbness or Tingling		**For Men Only**	
Frequent Indigestion		Unconsciousness		Prostate Problems	
Difficulty swallowing		Emotional Problems		Sores on Penis	
Changes in Appetite		Severe Depression		Testicular Abnormality	
Stomach/Duodenal Ulcer		Excessive Fatigue		**For Women Only**	
Intestinal Trouble/Colitis		Substance Abuse		Abnormal Pap Smear	
Vomiting Blood		Eye Trouble		Female Problems	
Changes in Bowel Habits		Color Blindness		Menstrual Pain	
Black or Tarry Stools		Glaucoma		Menstrual Irregularity	
Constipation		Ear Inujry or Trouble		Are you now pregnant?	
Chronic Diarrhea		Hearing Problems		Date of Last Menstrual Period	
Rectal Bleeding		Ringing in Ears		Date of Last Pap Smear	
Gall Bladder Disease		Dizziness		**For Men and Women**	
Liver Disease		Nose Trouble/Injury		# of Pregnancies (Self or Spouse)	
Hepatitis		Throat Trouble		# of Normal Births	
Jaundice (Yellow Skin)		Frequent Sore Throats			

Since your last examination, have you: (if YES) please explain in space provided)

Question	YES	NO	EXPLANATION		
Received medical treatment?					
Been advised to have an operation?					
Developed sensitivity to any foods, drugs or other materials?					
Started using any medications regularly (OTC or prescription)?					
Had any illness or injury which you consider to be related to your job?					
Do you exercise regularly?					
Do you currently use tobacco?			How much?	Years Used?	Type?
Have you ever used tobacco?			How much?	Years Used?	Quit Date?
Do you consume alcohol?			How much?	How often?	☐Daily ☐Weekly ☐Occasionally
Do you wear your seat belt regularly?					

Signature ______________________________________ Date ______________________