1614 Peachtree Parkway ▪ Suite #200 ▪ Cumming, GA 30041
Phone: **(678) 455-2295** Fax: **(678) 455-2279** **www.cummingprimarycare.com**

Medical History

Full Name__________________________________ Date of Birth__________ Date____________________
Do you have a living will? □ Yes □ No Healthcare Proxy? □ Yes □ No If yes, who?_____________
Do you have Advance Directives for Healthcare? □ Yes □ No If yes, please provide a copy to front office.
Please list all specialty physicians you see:____
____

Present Health Concerns (Please list reasons for your visit today in order of priority):

1. ____
2. ____
3. ____
4. ____
5. ____

Allergies:

Medication	Reaction or Side Effect

Medications (including non-prescription medications, birth control, vitamins, herbs and supplements):

Medications	Dosage

Past Medical History (Please check any illnesses or conditions you have had):

□ Acid Reflux	□ Bronchitis	□ Glaucoma	□ Hypertension	□ Sickle Cell Disease
□ Alcoholism	□ Cancer________	□ Gout	□ Irregular heartbeat	□ Sleep Apnea
□ Anemia	□ Crohn's Disease	□ Hay Fever	□ Jaundice	□ Stomach Ulcer
□ Aneurysm	□ COPD	□ Headaches	□ Kidney Disease	□ Stroke
□ Anxiety Disorder	□ Depression	□ Heart Disease	□ Kidney Stones	□ Substance Abuse
□ Arthritis	□ Diabetes	□ Heart Failure	□ Liver Disease	□ Thyroid Disease
□ Asthma	□ Emphysema	□ Heart Murmur	□ Obesity	□ Tuberculosis
□ Blood Disorder	□ Epilepsy	□ Hepatitis A, B or C	□ Osteoporosis	□ Ulcerative Colitis
□ Blood Clots	□ Fractures	□ High Cholesterol	□ Prostate Problems	□ Other __________
□ Blood Transfusion	□Gallbladder problem	□ HIV/AIDS	□ STD ___________	□________________

Past Surgical/Hospitalization History (Please list all prior operations and dates):

Operations	Date	Hospitalizations	Date

Family Medical History (List all medical illnesses in your blood relatives): ◻ Adopted

Family Member	Major Medical Problems	Family Member	Major Medical Problems
Mother		Father	
Maternal Grandparents		Paternal Grandparents	
Aunts		Uncles	
Sisters		Brothers	
Daughters		Sons	

Social History

Occupation: ___________________________ Marital Status: _________________ Children:◻ Yes ◻ No
Do you drink alcohol? ◻ Yes ◻ No How Often? ___________________ How many drinks?_________
Do you smoke? ◻ Yes ◻ No Packs per day?_________________ How many years?__________
Are you a former smoker? ◻ Yes ◻ No Year quit?_________ Do you chew tobacco? ◻ Yes ◻ No
Do you Exercise? ◻ Yes ◻ No How long? ____________ per day/week/month
Do you use recreational/illegal drugs? ◻ Yes ◻ No If yes, what drug(s)?_________________________
Have you ever worked with asbestos or other hazardous materials? ◻ Yes ◻ No

Health Maintenance:

Last annual physical exam ____________ Last stress test ______________ Last cholesterol check _____________

Last menstrual period _______________ Last Pap smear ______________ Last mammogram ________________

Last prostate screening ______________ Last Colonoscopy ____________ Last bone density test _____________

Immunizations: Flu _______ Pneumovax _______ Tetanus ________ Hepatitis A ________ Hepatitis B _____

Review of Symptoms (please check if you recently had the following symptoms):

◻ Weight Gain/Loss	◻ Runny nose	◻ Palpitations	◻ Urinary leakage	◻ Anxiety/Stress
◻ Excessive thirst	◻ Nose Bleed	◻ Fainting	◻ Painful intercourse	◻ Mood changes
◻ Feeling too cold	◻ Fever/Chills	◻ Nausea/Vomiting	◻ Erection problems	◻ Depression
◻ Feeling too hot	◻ Cough	◻ Diarrhea	◻ Penis discharge	◻Skin rash/discoloration
◻ Night sweats	◻ Blood in sputum	◻ Constipation	◻ Vaginal discharge	◻ Joint pain
◻ Weakness	◻ Shortness of breath	◻ Blood in stool	◻ Breast lump/pain	◻ Back pain
◻ Fatigue	◻ Chest discomfort	◻ Blood in Vomit	◻ Headache	◻ Leg pain
◻ Insomnia	◻ Irregular Heart beat	◻ Heartburn	◻ Dizziness	◻ Leg swelling
◻ Change in Hearing	◻ Exercise Intolerance	◻ Easy bruising	◻ Memory problems	◻ Other __________
◻ Change in Vision	◻Difficulty swallowing	◻ Urinary problems	◻ Tingling/Numbness	◻_______________

Patient/Guardian Signature ______________ Patient Name (Please print) ______________ Date ______ Time ______

Relation to patient ______________ Reason patient is unable to sign ______________