COMPASS PRIMARY CARE, LLC

Name _____ DOB: _____Date: _____

YOUR MEDICAL HISTORY:

Asthma	☐Yes ☐No	Heart disease/ heart attack	☐Yes ☐No	Blood clots	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Cancer_____	☐Yes ☐No	Seizures	☐Yes ☐No
Diabetes	☐Yes ☐No	High/Bad Cholesterol	☐Yes ☐No	Enlarged prostate	☐Yes ☐No
Emphysema/COPD	☐Yes ☐No	Stroke	☐Yes ☐No	HIV/ AIDS	☐Yes ☐No
Autoimmune disease	☐Yes ☐No	Anxiety	☐Yes ☐No	Glaucoma	☐Yes ☐No
Heartburn/ reflux	☐Yes ☐No	history of alcohol or drug abuse	☐Yes ☐No	COVID 19	☐Yes ☐No
Thyroid disease	☐Yes ☐No	depression	☐Yes ☐No		

☐Other medical problems: _____

SURGERIES: ☐No surgeries ☐gall bladder removed ☐ Partial hysterectomy ☐ total hysterectomy _____

☐Other _____

Medications:_____

(Use back of page if needed)

Preferred pharmacy:_____Drug allergies:_____

FAMILY HISTORY Please list who has or had the follow conditions: (mother, father, brother, sister paternal or maternal)

☐High Blood Pressure _____ ☐Diabetes_____

☐High Cholesterol _____ ☐Cancer (Type) _____ age _____

☐Coronary Artery Disease_____ ☐before age 50 ☐Heart Attack_____☐before age 50

☐Sudden Death_____ ☐Heart Failure_____

☐Stroke_____☐Seizures_____ ☐Mental illness_____

☐ other_____

☐None of the Above

Mother ☐alive ☐deceased ____age ☐unknown **Father** ☐alive ☐deceased ____age ☐unknown **Maternal Grandmother**☐alive ☐deceased ____age ☐unknown **Maternal Grandfather** ☐alive ☐deceased ____age ☐unknown **Paternal Grandmother** ☐alive ☐deceased ____age ☐unknown **Paternal Grandfather** ☐alive ☐deceased ____age ☐unknown

Brothers: how many?_____Deceased:_____

Sisters: how many?_____Deceased:_____

Sons: how many?_____ _Deceased_____ Daughters: how many ?_____ Deceased_____

SOCIAL HISTORY:

Do you wear your seat belt? ☐Yes ☐No ☐Sometimes Do you exercise? ☐Yes ☐No If so, how often_____

Do you feel safe in your home/ relationship? ☐Yes ☐No Have you ever been made to have sex against your will? ☐Yes ☐No

Have you ever had sex? ☐Yes ☐No Have you had sex in the last 12 months? ☐No ☐Yes

Do you have sex with men? ☐Yes ☐No Do you have sex with women? ☐Yes ☐No ☐ I do not have sex ☐Other_____

Number of sexual partners in last 12months_____

☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐ Partnership ☐Other_____

What birth control do you use? ☐none ☐pills ☐condoms ☐my partner takes care of this ☐vasectomy ☐_____

Job/ Occupations/ what I do during the day:_____

Do you do any of the following:

Smoke/ tobacco? ☐No ☐Yes ☐ former smoker If so, how many packs per day (now or in past)? _____

Drink Coffee/Soft drinks/Tea: ☐No ☐Yes If so, how many cups per day? _____

Drink Alcohol: ☐No ☐Yes if so, how much/how often? _____ Have you ever felt you should cut down on your drinking? __Yes __No Have people annoyed you by criticizing your drinking? __Yes __No Have you ever felt bad or guilty about your drinking? __Yes __No Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? __Yes __No Do you vape?☐No ☐Yes

Use street drugs: ☐No ☐Yes ☐ Yes, but in the past. If so, what drug(s)? _____

COMPASS PRIMARY CARE, LLC

Name _____DOB: _____

.Last mammogram_____Last pap smear_____ Last bone density_____

Last prostate check_____Last colon cancer screening_____Last eye exam:_____

Do you want a **flu shot** (Flu season is from Sept-Feb)? ☐Yes ☐No last vaccine _____

Shingles: ? ☐Yes ☐No last vaccine _____ **Tetanus** Vaccine? ☐Yes ☐No last vaccine _____

Pneumonia vaccine (Only if age>50, smoker, kidney, lung, heart disease, or asthma) ☐Yes ☐No

last vaccine_____

Over the last 2 weeks how often have you been bothered by any of the following	Not at all	A few days a week	More than ½ the week	Almost everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Over the last 2 weeks how often have you been bothered by any of the following	Not at all	A few days a week	More than ½ the week	Almost everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3