DUBLIN PRIMARY CARE

Date of Service: ____________

2685 Dublin Boulevard
Colorado Springs, CO 80918
(719) 592-9890

Medical History Sheet

Name: ____________ Date of Birth: ____________

Reason for today's visit: ____________

Circle the following items that apply to you, your father (F), mother (M), or grandparent (G):

		Circle One			Circle One
Allergies	Self	F / M / G	Kidney disorder	Self	F / M / G
Asthma	Self	F / M / G	Prostate disorder	Self	F / M / G
Anemia	Self	F / M / G	Seizures	Self	F / M / G
Arthritis	Self	F / M / G	Skin Cancer	Self	F / M / G
Blood disorder	Self	F / M / G	Skin problems	Self	F / M / G
Cholesterol disorder	Self	F / M / G	Stomach/digestive disorder	Self	F / M / G
Depression	Self	F / M / G	Stroke	Self	F / M / G
Diabetes	Self	F / M / G	Thyroid problem	Self	F / M / G
Hearing problems	Self	F / M / G	Vision problems	Self	F / M / G
Heart disease	Self	F / M / G	Cancer (specify type)	Self	F / M / G
Heart murmur	Self	F / M / G	____________	Self	F / M / G
HIV/Hepatitis	Self	F / M / G	Other:	Self	F / M / G
Hypertension	Self	F / M / G	____________	Self	F / M / G
Lung disease	Self	F / M / G	____________	Self	F / M / G

Do you Smoke or use Tobacco? (circle one) Y N
If yes, how often and how much? ____________
Do you consume alcohol? Y N
If yes, how often and how much? ____________

Do you Exercise? Y N
How Often? ____________

Please list all surgeries you have undergone:

1.
2.
3.
4.
5.
6.

Are you taking any prescription medications? Yes No (If yes list below)

Medication Name:	Dose/Frequency:
1.	
2.	
3.	

4.

5.

6.

Do you have any drug allergies? Yes No If yes, list below:

For Women Only

Are you currently taking Birth Control? Yes No

Date of last PAP smear ________/________/________

Number of pregnancies/births /

Date of last breast exam ________/________/________

For Men & Women

Date of last colonoscopy ________/________/________

Are your immunizations up to date? Yes No

Date of Last bone density ________/________/________

Date of your last Tetanus? ________/________/________