PRIMARY MEDICAL SERVICES, P.C.
FAMILY MEDICINE & URGENT CARE
PATRYCJA CZESNOWSKI, M.D.

HEALTH HISTORY

Date: _____ / _____ / _____

Name: _____ **DOB:** _____ / _____ / _____
LAST FIRST MIDDLE

When was your last yearly exam / Pap smear? _____ Normal or Abnormal
Smoking Status: Current Smoker _____ / PPD _____ / Years _____ / Quit/Year _____ / Never _____
Alcohol: Yes _____ / No _____ / Socially _____ **Amount:** _____per day / week / month
Drug Use: Never _____ / Past (enter when last used): _____ / Intravenous Drug Use (even if used only once): _____

ALLERGIES: Please circle Yes or No if you have had a reaction to any of the following or list allergy to medication:

Medication			What Type of Reaction	Medication	What Type of Reaction
Latex	YES	NO			
Penicillin	YES	NO			
Sulfa	YES	NO			

MEDICATIONS:

Medication	Strength	How Often	Medication	Strength	How Often

PAST MEDICAL HISTORY:

Diagnoses			If YES, explain	Diagnoses			If YES, explain
Aneurysm	YES	NO		Epilepsy or Seizures	YES	NO	
Anxiety	YES	NO		GERD	YES	NO	
Arthritis	YES	NO		Headaches or Migraines	YES	NO	
Asthma	YES	NO		Heart Problems	YES	NO	
Atrial Fibrillation	YES	NO		Hepatitis A / B / C	YES	NO	
Blood Clots	YES	NO		HIV / AIDS	YES	NO	
Blood Pressure	YES	NO		Hyper/hypo-thyroidism	YES	NO	
Cancer	YES	NO		Kidney Disease / Failure	YES	NO	
COPD	YES	NO		Kidney Stones / Infection	YES	NO	
Crohn's Disease	YES	NO		MRSA Infections(s)	YES	NO	
Dementia	YES	NO		Pneumonia	YES	NO	
Depression	YES	NO		Stroke	YES	NO	
Diabetes	YES	NO		Tuberculosis	YES	NO	

PAST SURGICAL HISTORY: (operations with the most recent listed first):

Year	Type of Surgery	Hospital

FAMILY HISTORY:

Diagnoses			Who: Maternal (mother's side) / Paternal (father's side)
Breast Cancer	YES	NO	
Colon Cancer	YES	NO	
Heart Disease / Stroke	YES	NO	
Ovarian Cancer	YES	NO	
Prostate Cancer	YES	NO	

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