GoPrivateMD

General Information & History

Name:____**Date:**______________________

Date of Birth:_____________________ **Age:**______________**Sex:** **Male** **Female**

Address:____

City:________________________________ **State:** _______________________**Zip:** _________________

Telephone:__________________________ **Email:**____

PREFFERED PHARMACY NAME & LOCATION:____

PREFFERED LAB: QUEST TRICORE

PRIMARY PHYSICIAN:____

SPECIALISTS:____

INSURANCE

GoPrivateMD will not bill your insurance. Insurance is used for labs, prescriptions and other tests that may be necessary.

Name of Insurance Company:____

Member ID:____

Group#:____

Insurance company address and telephone:____

____

VITALS

To be completed by GPMD Staff

Height	
Weight	
Blood Pressure	
Respiratory Rate	
Pulse	
O2 Saturation	

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CURRENT ISSUES/PROBLEMS

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Hypothyroidism
☐ Goiter
☐ Cancer (type)
☐ Leukemia
☐ Psoriasis
☐ Angina
☐ Heart Problems
☐ Heart murmur
☐ Pneumonia
☐ Asthma
☐ Emphysema
☐ Stroke
☐ Epilepsy
☐ Cataracts
☐ Kidney disease
☐ Kidney stones
☐ Crohn's disease
☐ Colitis
☐ Anemia
☐ Jaundice
☐ Hepatitis
☐ Stomach/peptic ulcer
☐ Rheumatic fever
☐ Tuberculosis
☐ HIV/AIDS

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SURGICAL HISTORY

List all surgeries and dates:

PRIOR HOSPITALIZATIONS

List reason for hospitalization and dates:

ALLERGIES

Drug Allergies:

Food Allergies:

Environmental Allergies:

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SYSTEMS REVIEW

GENERAL

☐ Recent weight gain: how much
☐ Recent weight loss: how much
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

MUSCLE/JOINT/BONES

☐ Numbness
☐ Joint pain
☐ Muscle weakness
☐ Joint swelling
Where?

EARS

☐ Ringing in ears
☐ Loss of hearing

EYES

☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness

THROAT

☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing
☐ Pain in jaw

HEART AND LUNGS

☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Fainting
☐ Swollen legs or feet
☐ Cough

NERVOUS SYSTEM

☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Numbness or tingling
☐ Memory loss

STOMACH & INTESTINES

☐ Nausea
☐ Heartburn
☐ Stomach pain
☐ Vomiting
☐ Yellow jaundice
☐ increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

SKIN

☐Redness
☐ Rash
☐ Nodules/bumps
☐ Hair Loss
☐ Color changes of hands or feet

BLOOD

☐ Anemia
☐ Clots

KIDNEY/URINE/BLADDER

☐ Frequent or painful urination
☐ Blood in urine

WOMEN ONLY:

☐ Abnormal Pap smear
☐ Irregular periods
☐ Bleeding between periods
☐ PMS

PSYCHIATRIC

☐ Depression
☐ Excessive worries
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulties with sexual arousal
☐ Poor appetite
☐ Food cravings
☐ Frequent crying
☐ Sensitivity
☐ Thoughts of suicide/attempts
☐ Stress
☐ Irritability
☐ Poor concentration
☐ Racing thoughts
☐ Guilty thoughts
☐ Paranoia
☐ Mood swings
☐ Anxiety
☐ Risky behavior

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PERSONAL HISTORY

Where were you born and raised?____

Highest level of education? ❑ High school ❑ Some college ❑ College graduate ❑ Advanced degree

Marital status: ❑ Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/Significant other

Spiritual/Religion:____

What is your current or past occupation?____

Have you ever served in the military? Y/N Which branch?_______________**Role:**_______________

Are you currently working? Y / N Hours/Week_____**If not, are you?** ☐ **Retired** ☐ **Disabled** ☐ **Sick leave**

Do you receive disability or SSI? Y / N If yes, for what disability, how long?

SOCIAL HISTORY

Alcohol use: Y / N Drinks per day:___________**Tobacco use: Y / N Amount per day:**___________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health and Psychiatric	Age(s) at Death	Cause
Father				
Mother				
Siblings				
Siblings				

EXTENDED FAMILY PROBLEMS PAST & PRESENT

Maternal Relatives:

Paternal Relatives:

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PREVENTATIVES AND VACCINES

VACCINES	YES	NO	DATE	NOTES
Flu				
Tdap				
Shingles				
Pneumonia				
PREVENTATIVES	**YES**	**NO**	**DATE**	**NOTES**
Colonoscopy				
Mammogram				
Pap				

NMIIS YES NO
(For office use only)

Name:______________________________________

FEMALES ONLY

REPRODUCTIVE HISTORY

Age of first period:____

 # Miscarriages:____

 # Abortions:____

 # Children (including step)____

Have you reached menopause? Y / N **At what age?**_________________________________

Do you have regular periods? Y / N