AGAPÉ PRIMARY CARE

Location:_____

**Patient Name**_____ **Date of Birth**_____

### General

- □ Chills
- □ Depression/Nervousness
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Numbness
- □ Sweats

### Gastrointestinal

- □ Appetite Poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting and/or with blood

### Eye/Ear/Nose/Throat

- □ Bleeding Gums
- □ Blurred Vision
- □ Crossed Eyes
- □ Difficulty Swallowing
- □ Double Vision
- □ Earache/Ear Discharge
- □ Hay Fever
- □ Hoarseness
- □ Loss of Hearing
- □ Nosebleeds
- □ Persistent Coughs
- □ Ringing in Ears
- □ Sinus Problem
- □ Vision - Flashes/Halos

### Genito-Urinary

- □ Blood in Urine
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

### Tobacco History

Ever used tobacco products? □ Yes □ No
What kind?_____
How many years?_____
Date quit:_____

### Women Only

| | | |
|---|---|---|
| □ | Abnormal Pap Smear | Date of Last Pap Smear _____ |
| □ | Bleeding Between Periods | Date of Last Period _____ |
| □ | Breast Lump | Are you Pregnant? _____ |
| □ | Extreme Menstrual Pain | Date of Last Mammogram _____ |
| □ | Hot Flashes | Number of Live Births? _____ |
| □ | Nipple Discharge | Number of Miscarriages? _____ |
| □ | Painful Intercourse | How often do you |
| □ | Vaginal Discharge | examine your breasts? _____ |
| □ | Other | Name of OB/GYN |

### Men Only

| | | |
|---|---|---|
| □ | Erection Difficulties | How often do you do a |
| □ | Lump in Testicles | Testicular exam? _____ |
| □ | Penis Discharge | Last Prostate Blood |
| □ | Sore on Penis | Test (PSA)? _____ |
| □ | Other | Last prostate/rectal exam? |

### Cardiovascular

- □ Chest Pain
- □ High/Low Blood Pressure
- □ Irregular/Rapid Heartbeat
- □ Poor Circulation
- □ Swelling of Ankles
- □ Varicose Veins

### Muscle/Joint/Bone

- □ Pain, weakness, numbness in:
- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Hips
- □ Legs
- □ Neck
- □ Shoulder

### Skin

- □ Bruise Easily
- □ Hives
- □ Itching/Rash
- □ Changes in Mood
- □ Scars
- □ Sore that will not heal

### Preventative Care

Tetanus Booster _____
Flu Shot_____
Pneumonia Vaccine_____
Hepatitis Vaccine_____
Colonoscopy_____

### Family/Medical History (Check box if it applies to you and/or write in family relationship)

| | | |
|---|---|---|
| High Blood Pressure | □ | _____ |
| Diabetes | □ | _____ |
| Stroke | □ | _____ |
| Cancer | □ | _____ |
| Type of Cancer | □ | _____ |
| Heart Attack | □ | _____ |
| Heart Surgery | □ | _____ |
| Osteoporosis | □ | _____ |
| Arthritis | □ | _____ |
| Alcoholism | □ | _____ |
| Asthma | □ | _____ |
| Epilepsy | □ | _____ |
| Mental Illness | □ | _____ |
| Substance Abuse | □ | _____ |
| Thyroid Disease | □ | _____ |
| Blood Clots | □ | _____ |
| Depression/Suicide | □ | _____ |
| Alzheimer's | □ | _____ |
| Glaucoma | □ | _____ |
| High Cholesterol | □ | _____ |
| Liver Disease | □ | _____ |
| Kidney Disease | □ | _____ |
| Stomach Problems | □ | _____ |
| Reflux Disease | □ | _____ |
| Other | □ | _____ |

### Alcohol/Drug History

Do you drink alcohol? □ Yes □ No
How many drinks per week?_____
Do you use drugs? □ Yes □ No
How often?_____

AGAPÉ PRIMARY CARE

Location:_____

**Patient Name**_____ **Date of Birth**_____

**Please list disease related deaths,** if applicable**:**

| | | |
|---|---|---|
| Mother's Age | _____ | Cause of Death_____ |
| Father's Age | _____ | Cause of Death_____ |
| Sibling's Age, if applicable | _____ | Cause of Death_____ |
| Maternal Grandmother's Age | _____ | Cause of Death_____ |
| Maternal Grandfather's Age | _____ | Cause of Death_____ |
| Paternal Grandmother's Age | _____ | Cause of Death_____ |
| Paternal Grandfather's Age | _____ | Cause of Death_____ |

**Current Medications** (use reverse side if necessary):_____

_____

_____

_____

_____

**Preferred Pharmacy**: _____

**Telephone Number**:_____

**Allergies to medications and/or substances:** _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child or person for whom I am Healthcare Power of Attorney/Power of Attorney, has changes in health.

_____ _____

Authorized Signature Printed Name of Authorized Signature

_____

Date