Prime MD of Naples
COMPREHENSIVE PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help us better understand your medical concerns and conditions.

Main reason for today's visit: _____

ALLERGIES: List anything you are allergic to: medications, food, etc and how it affects you

	ALLERGY	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____

MEDICATIONS

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

WOMEN ONLY

Last PAP smear Date: _____ Last Mammogram Date:_____

Age at menopause: _____

Number of pregnancies: ____ births: ____

PAST MEDICAL HISTORY: Please Check all that apply

☐ Anxiety/Depression	☐ Diverticulitis	☐ Memory problems
☐ Arthritis	☐ Fibromyalgia	☐ Neurologic conditions
☐ Asthma	☐ Gout	☐ Obesity
☐ Anemia	☐ Has Pacemaker	☐ Osteoporosis
☐ Blood Clots (or DVT)	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Headaches	☐ Thyroid
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux	☐ Prostate
☐ COPD	☐ High Cholesterol	☐
☐ Congestive Heart Failure	☐ Hospitalizations	☐
☐ Diabetes	☐ Kidney disease/stones	☐
☐ Dialysis	☐ Liver Disease	☐

Andre Nye, MD, Cosmina Popa, MD
www.primemdofnaples.com
2515 Northbrooke Plaza Dr., Ste 200, Naples, FL
P: 239-325-6955

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SURGERIES: Please list type and date

1. _____
2. _____
3. _____

SOCIAL HISTORY

OCUPATION
_____

MARITAL STATUS
☐ Married ☐ Single
☐ Divorced
☐ Separated ☐ Widowed
☐ Domestic partner
EXERCISE LEVEL _____

CAFFEINE
☐ None
# of cups/cans per day? _____

ALCOHOL
Do you drink alcohol?
☐ Yes ☐ No
If so, how much? _____

TOBACCO
Did you ever use tobacco?
☐ Yes ☐ No
☐ # of years /Quit date_____

DRUGS
Do you currently use recreational or street drugs?
☐ Yes ☐ No
If yes, list: _____

REVIEW OF SYSTEMS: Please check all that apply

Allergic/Immunologic
☐ Frequent Sneezing
☐ Hives
☐ Itching
☐ Runny Nose

Cardiovascular
☐ Arm Pain on Exertion
☐ Chest Pain on Exertion
☐ Irregular Heart Beats
☐ Heart Murmur
☐ Shortness of breath
☐ Swelling (edema)

Constitutional
☐ Fatigue
☐ Night sweats
☐ Fever
☐ Weight Gain
☐ Weight Loss

☐ Dry Eyes
☐ Irritation
☐ Vision Change

Ears/Nose/Mouth/Throat
☐ Difficulty Hearing
☐ Dry Mouth
☐ Ear Pain
☐ Frequent Nosebleeds
☐ Hoarseness
☐ Mouth Ulcers
☐ Nose/Sinus Problems
☐ Ringing in Ears

Endocrine
☐ Fatigue
☐ Increased Thirst Hunger/Urination

Gastrointestinal
☐ Abdominal Pain
☐ Black Stool
☐ Blood in Stool
☐ Change in Appetite
☐ Frequent Indigestion
☐ Hemorrhoids
☐ Trouble Swallowing
☐ Vomiting
☐ Vomiting Blood

Genitourinary
☐ Blood in Urine
☐ Difficulty Urinating
☐ Incomplete Urinary Emptying
☐ Urinary Loss of Control

Hematologic/Lymphatic
☐ East Bruising / Bleeding
☐ Swollen Glands

Skin
☐ Changes in Moles
☐ Dry Skin
☐ Eczema
☐ Growth/Lesions
☐ Itching
☐ Rash

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Muscle Aches
☐ Muscle Weakness

Neurological
☐ Dizziness
☐ Headaches
☐ Memory loss
☐ Numbness
☐ Restless Legs
☐ Seizures
☐ Weakness

Psychiatric
☐ Alcohol Overuse
☐ Anxiety/Depression
☐ Mania
☐ Sleep Problems

Respiratory
☐ Cough
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Snoring/Sleep Apnea

Patient Signature and date: _____

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