PrimaryCareAssociates

NavicentHealthPhysicianGroup

1960 GA Hwy 247 Connector / Byron, GA 31008 / **PH: 478-654-2350**

Name: ______________________ Current Primary Care Physician: ____________________________

Date of Birth: _________Sex: ________ Referring Physician (if applicable): __________________________

Are you being seen by any other specialists? If so, list physician name: __________________________________

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Preferred Pharmacy: ________________ Pharmacy Phone#: __________________________

Dentist: _____________________________ Dentist Phone #: ____________________________

PLEASE BRING A CURRENT MEDICATION LIST OR MEDICATION BOTTLES TO YOUR APPOINTMENT

Are you Allergic to any medications? Yes □ No □

If yes, list medication(s) and reaction: ____

Are you allergic to X-ray dye or shellfish? Yes□ No □ What type of reaction? ___________________________

FAMILY MEDICAL HISTORY		
	Health Problems	**If deceased, age and cause of death**
Father		
Mother		
Sibling(s)		

PATIENT SOCIAL HISTORY	
Smoking Status	Never □ Current □ Former □ How many packs per day? __________ # of years? _________
Do you Vape?	Yes □ No □ If yes, how long have you been vaping? ________________
Alcohol Use	Yes □ No □ □ Wine □ Beer □ Liquor If yes, about how many drinks per day? ____________
Illicit Drugs	Never □ Current □ Former □ If yes, what type? _______________ # of years? _________
Marital Status	Single □ Married □ Divorced □ Widowed □
OB/GYN History	Age at start of Menstruation: ____ Last Menstrual Period: __________ Last Pap: ___________ Last Mammogram: ____________ Are you currently pregnant? Yes □ No □ # of Pregnancies: _______ # of Miscarriages ______ # of Abortions _______ # Living Children ________
	Highest level of education completed ______________________ Year of completion: ___________

Name:
DOB:

Past Medical History (Please mark if Yes)					
Endocrine		**Neurologic**		**Renal/ Genitourinary**	
Diabetes	☐	Migraines	☐	Kidney Disease	☐
Hypoglycemia	☐	Seizures/ Epilepsy	☐	Kidney Stones	☐
Hyperthyroidism	☐	Stroke	☐	Prostate Problems	☐
Hypothyroidism	☐	TIA	☐	Urinary Tract Infections	☐
Gastrointestinal		**Musculoskeletal**		**Pulmonary**	
Bleeding Ulcer	☐	Arthritis	☐	Asthma	☐
Gastroesophageal Reflux	☐	Back Pain	☐	COPD	☐
Liver Disease	☐	Gout	☐	Emphysema	☐
Peptic Ulcer Disease	☐	Herniated Disc	☐	Sleep Apnea	☐
Hematologic/ Oncology		**Cardiovascular**		**Other conditions not listed**	
Anemia	☐	High Cholesterol	☐		
Blood Clots	☐	High Blood Pressure	☐		
Bleeding Disorder	☐	Heart Disease	☐		
Cancer	☐	CHF	☐		
Type of Cancer:		Heart Attack	☐		
Infections Disease		Heart Valve Disease	☐		
Hepatitis	☐	Irregular Heart Beats	☐		
HIV/ AIDS	☐	Defibrillator	☐		
Polio	☐	Pacemaker	☐		
Rheumatic Fever	☐	Cardiac Stent/ Procedure	☐		
Tuberculosis	☐	PVD	☐		

***Please explain any yes answers**:*

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Review of Systems (Please mark if you are experiencing these symptoms)					
Nausea	☐	Chronic Cough	☐	Swelling in feet	☐
Vomiting	☐	Chest Pain	☐	Skin Discoloration	☐
Heart burn	☐	Shortness of breath	☐	Skin rash	☐
Changes in weight	☐	Dizziness	☐	Abdominal Pain	☐
Changes in appetite	☐	Passing out	☐	Arm or hand pain	☐
Changes in bowel habits	☐	Pain or discomfort in your legs when sitting	☐	Pain or discomfort in your legs when standing	☐
Pain or discomfort in your legs when walking	☐	Sudden weakness on one side of your body	☐	Numbness on one side of your body	☐
Pain or discomfort in your legs while lying flat	☐	Loss of the ability to talk or write	☐	Sores/ ulcers on legs or feet	☐
Sudden loss of vision in one or both eyes	☐				

Please explain any yes answers:

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Name:
DOB:

Past Surgical History *(List any previous surgeries or procedures, and dates ie: tonsillectomy, wisdom teeth removal, colonoscopy, heart catheterizations)*		
Procedure	**Date**	**Physician**

Medications *(Please list all prescription medication, supplements, and over the counter medications.)*			
Medication	**Dose**	**Frequency**	**Reason for taking**

FOR OFFICE USE ONLY *(Additional Information/ Comments/ Note)*

Name:
DOB: