PCIFM
~est. 2012~
Pell City Internal & Family Medicine

Name:

Social Habits

Have you ever used tobacco products? ☐ Yes ☐ No
What kind? ______
How much? ______
For how many years? ______
Date quit ______

Do you drink alcohol? ☐ Yes ☐ No
How many drinks per week? ______
Have you ever felt you need to cut down? ☐ Yes ☐ No
Have you ever felt guilty about your drinking? ☐ Yes ☐ No
Do you use drugs? ☐ Yes ☐ No What type? ______

Do you exercise regularly? What form? ______
Briefly describe your diet: ______
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Are you sexually active with: ☐ 1 partner ☐ multiple partners ☐ with women ☐ with men ☐ none
Any history of sexually transmitted disease? (Type/year) ______
Who do you live with? ______ Do you feel safe at home? ☐ Yes ☐ No
If parent, what are the ages of your children? ______ ______ ______ ______ ______ ______
Briefly describe your diet: ______
Occupation: ______ Place of employment ______ Work Phone # ______
Your Pharmacy Name: ______ Address: ______ Tel #: ______

Family History

Has anyone in your family had any of the following? (Check appropriate box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Aunts/ Uncles	Details
Age (current or at death)							
High Blood Pressure							
MI/CVA (what age?)	Age:	Age:	Age:	Age:	Age:	Age:	
Diabetes							
Hyperlipidemia							
Cancer (type/location)							
Osteoporosis							
Depression/Dementia							Type:

Please check any of the following problems below that apply to you: ☐ No Problems

General
☐ Fever
☐ Sweats

Respiratory
☐ Cough
☐ Shortness of breath
☐ Pneumonia
☐ Wheezing
☐ Shortness of breath with exertion

Ear/Nose/Throat
☐ Ear pain
☐ Runny nose
☐ Sneezing
☐ Post nasal drip

Cardiovascular
☐ Chest pain or pressure
☐ Ankle swelling
☐ Palpitations

Genitourinary
☐ Urinary frequency
☐ Burning with urination
☐ Blood in urine
☐ Problems urinating
☐ Awaken at night to urinate #______
☐ Problems with sex
☐ Exposure to sexually transmitted disease

Mental Health
☐ Insomnia
☐ Guilt
☐ Depression
☐ Anxiety
☐ Suicidal thoughts

Skin
☐ Rash
☐ Changing mole
☐ Itching
☐ Slow healing wounds

Eyes
☐ Blurred vision
☐ Changing vision

Daily Living
☐ Violence in your home
☐ Changes in functional ability
☐ Changes in eating habits
☐ Changes in sleeping habits

Endocrine System
☐ Excessive urination
☐ Excessive thirst
☐ Fatigue
☐ Heat intolerance
☐ Cold intolerance

Neurologic System
☐ Numbness
☐ Tingling
☐ Headaches
☐ Weakness

Allergy
☐ Seasonal symptoms
☐ Sneezing
☐ Itchy eyes
☐ Runny nose
☐ Nasal congestion
☐ Post nasal drip

Hematologic System
☐ Easy bruising
☐ Easy bleeding
☐ Hard to stop bleeding

Musculoskeletal
☐ Joint swelling
☐ Joint pains
☐ Muscle pains

GI System
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Abdominal pain
☐ Diarrhea
☐ Blood in stool

Nutrition
☐ On a special diet
☐ Weight gain or loss greater than 10 pounds