FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Primary Care
Health History Questionnaire

Name _____ **Date of Birth** ____/____/____

Current Health Concerns Please check problems or conditions that you are CURRENTLY experiencing				
☐ Chest pain/discomfort	☐ Abdominal pain	☐ Weight loss (lbs. _____)	☐ Loss of vision	☐ Insomnia
☐ Shortness of breath	☐ Heartburn	☐ Weight gain (lbs. _____)	☐ Double vision	☐ Depression
☐ Wheezing	☐ Indigestion	☐ Loss of appetite	☐ Memory lapses or loss	☐ Nervousness
☐ Cough	☐ Ankle swelling	☐ Difficulty swallowing	☐ Ringing in ears	☐ Pain in testicles
☐ Coughing up blood	☐ Nausea	☐ Painful urination	☐ Pain in ears	☐ Loss of libido
☐ Sore throat	☐ Vomiting	☐ Blood in urine	☐ Nose bleeds	☐ Impotence
☐ Nasal congestion	☐ Vomiting blood	☐ Urine frequency	☐ Hoarseness	☐ Breast pain
☐ Irregular heartbeat	☐ Change in bowel habits	☐ Decrease in urine flow	☐ Easy bleeding	☐ Breast discharge
☐ Fast heartbeat	☐ Rectal bleeding	☐ Urine leakage	☐ Easy bruising	☐ Other:
☐ High blood pressure	☐ Black/tarry stools	☐ Headaches, frequent	☐ Rash	
☐ Low blood pressure	☐ Hemorrhoids	☐ Loss of strength	☐ Changes in a mole	
☐ Lightheadedness	☐ Diarrhea	☐ Balance problems	☐ Sore that won't heal	
☐ Dizziness/fainting	☐ Constipation	☐ Eye pain	☐ Fatigue/lethargy	

Pain, weakness, or numbness in:

☐ Arms ☐ Hips ☐ Lower Back ☐ Legs ☐ Neck ☐ Shoulders ☐ Hands ☐ Feet ☐ Abdomen

Females - Please complete

Menstrual flow: ☐ Regular ☐ Irregular ☐ Pain/cramps ☐ Pain or bleeding after sex Menopause ☐ Y ☐ N Age: _____

1st day of last period: _____ Birth control method : _____

Days of flow: _____ Length of cycle: _____

Number of pregnancies: Number of Miscarriages:

Health Maintenance

Immunizations	Month	Year
Tetanus/Tdap		
Influenza		
Shingles		
Gardasil (HPV)		
Pneumonia -Please specify below		
☐ Pneumovax ☐ Vaxneuvance		
☐ Prevnar 13 ☐ Prevnar 20		

Tests	Month	Year
Mammogram		
Pap Smear/HPV Screening		
Colonsocopy/Cologuard		
Chest X-ray		
Prostate-Specific Antigen (PSA)		
Bone Density (DEXA)		
Low Dose Lung CT		

Patient/Guardian Signature: _____ Date: _____

Rev. 9.2024

Scanning Category: HHQ/Primary Care HHQ