Northern Light Mercy Hospital
144 State Street, Portland, ME 04101

MERCY PRIMARY CARE CONFIDENTIAL HISTORY

Date:

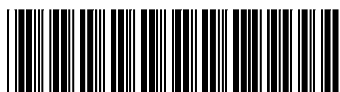
Last Name	First	Middle	Birth Date

FAMILY HISTORY:			If Living		If Deceased	
	Sex		Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sister* (*Circle Sex*)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters* (*Circle Sex*)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.*

Do you know of a blood relative who has or had: (*Circle and give relationship*)

Heart Attack or Heart Failure		Breast Cancer		Eczema		Mental Illness	
Stroke		Uterus or Cervical Cancer		Tuberculosis		Stomach Ulcers	
High Blood Pressure		Leukemia		Seizures/ Epilepsy		Colitis	
Diabetes		Other Cancer		Migraine		Rheumatoid Arthritis	
Kidney Disease		Asthma		Suicide		Glaucoma	
Colon Cancer		Hay Fever		Nervous Breakdown		Blindness or Near Blindness	
Alcoholism		Malignant Moles		Cystic Fibrosis			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(7/6/21)

Patient Identification

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Personal History:

1. Please describe your smoking habits:
Cigarettes cigars pipe chew eCigarettes/Vapping

year started_______ packs per day______
year quit _______ never ______

2. How many alcoholic drinks do you have? (beer, wine, liquor) per day ___________ on a weekend______
at a social event__________ never_________

3. How many cups of caffeine do you drink per day?

coffee, tea, soda:___________________________

4. Describe what kind of exercise you do:

5. Name any illnesses, conditions, diseases or diagnosis that you have or have had:

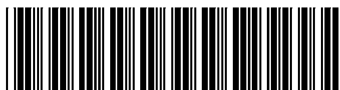
6. Serious injuries:

7. All operations or surgeries:

8. Any other hospitalizations and the reasons for them: Also include dates:

9. List all medications (please include aspirin, Tylenol, cold remedies, vitamins or supplements, tranquillizers, weight reducers, birth control pills, laxatives):

10. Allergies (name any drugs or food to which you are allergic):



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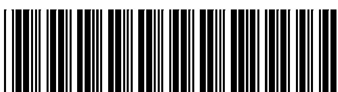
REVIEW OF SYSTEMS: Please check the adjacent box if you have had any of the conditions or problems mentioned below

	Chronic Fatigue		Diabetes
	Recent weight loss		Thyroid Disease
	Anemia		Cancer
	Bruise easily		Recent loss of appetite
	Sleeping difficulties		
	Frequent Headaches		Nervousness
	Convulsions/seizures		Depression
	Stroke		Memory loss
	Tremor hands shaking		Phobias
	Numbness/tingling sensations		Mental Illness
	Dizzy spells/fainting		
	Ringing in the ears		Recurrent nosebleeds
	Frequent ear infections		Sinus trouble
	Failing hearing		Frequent sore throats
	Failing vision		Prolonged hoarseness
	Double or blurred vision		Difficulty swallowing
	Frequent respiratory infections		Shortness of breath on exertion
	Chronic cough/bronchitis		Shortness of breath lying flat
	Coughing up blood		Hay Fever/allergies
	Asthma/wheezing		Tuberculosis
	Chest Pain, tightness or squeezing		High blood pressure
	Palpitations		Heart murmur
	Irregular pulse		Leg pain when walking
	Swollen ankles		Varicose veins/phlebitis
	Indigestion/heartburn		Diarrhea
	Persistent nausea/vomiting		Constipation
	Peptic ulcers/chronic abdominal pain		Bloody or tarry stools
	Recent change in bowel habits		Hemorrhoids
	Ribbon or pencil like stools		Gall bladder trouble
	Diverticulosis		Hepatitis/yellow jaundice
	Frequent urine infections		Decrease in force of urine stream
	Painful urination		Kidney stones
	Blood in urine		Venereal disease
	Frequent rising at night to urinate		Herpes
	Difficulty in controlling urine		Discharge from penis
			Hernia
	Arthritis/rheumatism		Gout
	Muscle weakness		Cold numb feet or foot pain
	Recurrent back pain		
	Rashes		Hives
	Eczema		Reactions to foods, stings, etc.
	Psoriasis		Sores that won't heal
			Worrisome moles
	Chicken pox		Polio
	Measles		Scarlet Fever
	German measles		Rheumatic Fever
	Last shot - tetanus		Mumps
	Last shot - Flu		Did you realize all of your childhood immunizations (shots)
	Last shot - Pneumonia		



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FOR WOMEN ONLY:

Age of first period_____________________________________
Periods regular or irregular______________________________
How many days between periods__________________________
How long is each period ______________________________
Date of start of last menstrual period_____________________
Number of pregnancies_______________________________
Complications:________________________________
Number of live births__________________________________
Complications__________________________________
Number of miscarriages_________________________________
Complications___________________________________
Types of birth control used_______________________________
Type using now____

☐ Discharge from nipple or breast
☐ Mother used DES
Pain or cramps with periods: ☐ heavy ☐ moderate ☐ light
Blood flow with periods: ☐ heavy ☐ moderate ☐ light
Pain or bleeding with intercourse______________________
Have you gone/are you going through the change of life? Y/N
Date of last menses_________________________________

Date of Last:

FOR MEN ONLY:

☐ Lumps in testicles

☐ Genital or prostate trouble
☐ Problems with sexual response

Preventive Care: Date of Last:

Screening Mammogram ________
Colorectal Screening:
Colonoscopy_______
Cologuard_________
Fecal Blood Test _______

Bone Density Scan _______

Immunizations:
Tetnus/Tdap_________
Shingles vaccine________
COVID vaccine ________
Pneumococcal vaccine _______

DESCRIBE BRIEFLY YOUR PRESENT PROBLEM

____
____
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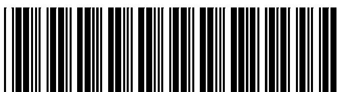
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