VICTORY PHYSICIANS

Primary Care Database Form

Competent medical care begins with a complete medical history. Please take the time to fill out this form as completely and truthfully as you are able. We will then enter it into your primary care file.

Name: _____ Date of Birth: _____

Physician, Clinic or Hospital History			
Facility/Provider Name	Location	Phone	Dates

Allergies to Medication(s)		
Medication Name	Reaction(s)	Immediate or Delayed Reaction

Allergies to Food(s)		
Food Name	Reaction(s)	Immediate or Delayed Reaction

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Current Medication(s)

Medication Name	Strength	Directions for Use	Last Refilled

Pharmacy Selection

What Pharmacies do you want us to send your electronic prescription(s) to in order of preference?

Pharmacy Name	Location
1.	
2.	
3.	

Family History

Relative	Living	Major Illnesses & Diseases During Life
Mother	☐ YES ☐ NO	
Father	☐ YES ☐ NO	
Sister(s)	☐ YES ☐ NO	
Brother(s)	☐ YES ☐ NO	

Vaccination History

Vaccination(s)	Completed	Date of Last Vaccination
Flu	☐ YES ☐ NO	
Pneumonia	☐ YES ☐ NO	
Tetanus	☐ YES ☐ NO	
HPV	☐ YES ☐ NO	
Zoster/Shingles	☐ YES ☐ NO	
Completed Childhood Vaccination Series	☐ YES ☐ NO	N/A
Other(s):		

Past Medical History

Diagnosis	Date of First Diagnosis

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Past Medical History Continued	
Diagnosis	Date of First Diagnosis

Past Surgical History	
Surgery	Date

Preventive Medicine		
Diagnosis/Procedure	Last Date	Ever Abnormal?
Complete Skin Examination		☐ YES ☐ NO
General Blood Panel		☐ YES ☐ NO
Cholesterol Check		☐ YES ☐ NO
Blood Sugar Check		☐ YES ☐ NO
Stress Test		☐ YES ☐ NO
Chest X-Ray		☐ YES ☐ NO
EKG		☐ YES ☐ NO
Blood Pressure		☐ YES ☐ NO
Colonoscopy		☐ YES ☐ NO
Stool Occult Blood		☐ YES ☐ NO
PSA		☐ YES ☐ NO
Testicular Evaluation		☐ YES ☐ NO
PAP Smear		☐ YES ☐ NO
Bone Density Scan		☐ YES ☐ NO
Breast Examination		☐ YES ☐ NO
Mammogram		☐ YES ☐ NO
Prostate Examination		☐ YES ☐ NO

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Social History			
Married ☐ Partner ☐ Single ☐ Widowed ☐ Divorced ☐			
Children	**Name**	**Age**	**City**
Child #1 – Boy or Girl			
Child #2 – Boy or Girl			
Child #3 – Boy or Girl			
Child #4 – Boy or Girl			
Child #5 – Boy or Girl			
Child #6 – Boy or Girl			
Child #7 – Boy or Girl			
Child #8 – Boy or Girl			
Child #9 – Boy or Girl			
Child #10 – Boy or Girl			
Palm Springs Area Resident: ☐ Year Round ☐ Seasonal			
Occupation:	Current:		
	Past:		
Areas of exceptional skill, knowledge or expertise:			
Favorite Music:			
Favorite Restaurant:			
Favorite Sports/Teams:			
Favorite Food:			
Favorite Film:			
Favorite TV Show:			
Favorite Book:			
Hobbies:			
Foreign Travel: Yes ☐ No ☐	If "Yes", where?		
Do you play any sports on a regular basis? Yes ☐ No ☐	If "Yes", which sports?		
Pets	**Name**	**Type**	**Age**
Pet #1 - Boy or Girl			
Pet #2 – Boy or Girl			
Pet #3 – Boy or Girl			
Pet #4 – Boy or Girl			
Pet #5 – Boy or Girl			
Pet #6 – Boy or Girl			
Educational Experience			
Highest level of education? ≤7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐			

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☐ JC_1 ☐ JC_2 ☐ C_1 ☐ C_2 ☐ C_3 ☐ C_4 ☐ Graduate School			
Degrees held: ☐ GED ☐ Bachelors ☐ Masters ☐ Doctorate			
List field(s) of specialty:	Bachelors	Masters	Doctorate
Schools you attended:			Years
High School: _____			_____
College: _____			_____
Graduate School:			

Alcohol use? Yes ☐ No ☐		
What do you drink?	About how much?	About how often?
Smoking? Yes ☐ No ☐		
What do you smoke?	About how much?	About how often?
Recreational drug use? Yes ☐ No ☐		
What do you use?	About how much?	About how often?
Blood transfusions? Yes ☐ No ☐ Date(s):		
Tattoos? Yes ☐ No ☐		
If yes, type: Parlor Homemade Jail	How many:	Location:
Body piercing(s)? Yes ☐ No ☐		
If yes, type: Parlor Homemade	How many:	Location:
Sexual preference?	♂ ☐ ♀ ☐ Both ☐ Neither ☐	
Sexual habits:	Protected? Always ☐ Sometimes ☐ Never ☐ Oral ☐ Anal ☐ Genital ☐ All ☐	
Caffeine: Yes ☐ No ☐		
Source:	How much:	How often:
Exercise: Yes ☐ No ☐		
What type(s):	Duration:	How often:
Military duty: Yes ☐ No ☐		

When:	Where:	Branch:	Unit:	MOS:

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Religion: Yes ☐ No ☐		
Which:		
Unusual water sources: Yes ☐ No ☐		
Which:		
Home slaughtered meat: Yes ☐ No ☐		
Which:		
Advanced Directives: Yes ☐ No ☐		
Durable Power of Attorney for Health Care Yes ☐ No ☐		
Who:	Contact Info:	Where kept:

REVIEW OF SYSTEMS

Constitutional		
Y ☐ N ☐ Fever	Y ☐ N ☐ Chills	Y ☐ N ☐ Night sweats
Y ☐ N ☐ Malaise	Y ☐ N ☐ Weakness	Y ☐ N ☐ Faintness
Y ☐ N ☐ Anorexia	Y ☐ N ☐ Increased thirst	Y ☐ N ☐ Weight gain
Y ☐ N ☐ Weight loss	Y ☐ N ☐ Insomnia	Y ☐ N ☐ Loss of interest
Y ☐ N ☐ Distracted	Y ☐ N ☐ Poor work perf.	
Cardiology		
Y ☐ N ☐ Chest pain	Y ☐ N ☐ Short of breath	Y ☐ N ☐ Almost passing out
Y ☐ N ☐ Passing out	Y ☐ N ☐ Weight gain	Y ☐ N ☐ Leg swelling
Y ☐ N ☐ Sweating	Y ☐ N ☐ Feeling doom	Y ☐ N ☐ Palpitations
Y ☐ N ☐ Dizziness	Y ☐ N ☐ Weakness	Y ☐ N ☐ Fatigue
Y ☐ N ☐ Night breath loss	Y ☐ N ☐ Cough	
Allergy		
Y ☐ N ☐ Rash	Y ☐ N ☐ Face swelling	Y ☐ N ☐ Tongue swelling
Y ☐ N ☐ Voice change	Y ☐ N ☐ Wheezing	Y ☐ N ☐ Cough
Y ☐ N ☐ Shortness breath	Y ☐ N ☐ Hard to breathe	Y ☐ N ☐ Itchy eyes
Y ☐ N ☐ Itchy nose	Y ☐ N ☐ Congestion	Y ☐ N ☐ Post nasal drip
Y ☐ N ☐ Sneezing	Y ☐ N ☐ Sore throat	Y ☐ N ☐ Sinus pressure
Y ☐ N ☐ Nose bleeds	Y ☐ N ☐ Eye fullness	
Gastrointestinal (GI)		
Y ☐ N ☐ Abdominal pain	Y ☐ N ☐ Pelvic pain	Y ☐ N ☐ Mass
Y ☐ N ☐ Hernia	Y ☐ N ☐ Nausea	Y ☐ N ☐ Vomiting
Gastrointestinal (GI) Continued		
Y ☐ N ☐ Blood in vomit	Y ☐ N ☐ Heart burn	Y ☐ N ☐ Blood in stool
Y ☐ N ☐ Tarry stools	Y ☐ N ☐ Brown vomit	Y ☐ N ☐ Hard to swallow
Y ☐ N ☐ Diarrhea	Y ☐ N ☐ Constipation	Y ☐ N ☐ Hemorrhoids
Y ☐ N ☐ Painful defecation	Y ☐ N ☐ Excess gas	Y ☐ N ☐ No gas
Y ☐ N ☐ Loud bowel sounds	Y ☐ N ☐ Anorexia	Y ☐ N ☐ Excess eating
Musculoskeletal		
Y ☐ N ☐ Muscle pain	Y ☐ N ☐ Joint pain	Y ☐ N ☐ Muscle swelling
Y ☐ N ☐ Joint swelling	Y ☐ N ☐ Muscle stiffness	Y ☐ N ☐ Muscle cramps
Y ☐ N ☐ Joint crunching	Y ☐ N ☐ Joint locking up	Y ☐ N ☐ Joint giving away
Y ☐ N ☐ Joint redness	Y ☐ N ☐ Decreased motion	Y ☐ N ☐ Excessive motion

Y ☐ N ☐ Pain on motion		
Ears, Nose and Throat (ENT)		
Y ☐ N ☐ Ear pain	Y ☐ N ☐ Ear fullness	Y ☐ N ☐ Ear discharge
Y ☐ N ☐ Hearing loss	Y ☐ N ☐ Runny nose	Y ☐ N ☐ Itchy nose
Y ☐ N ☐ Bloody nose	Y ☐ N ☐ Nasal congestion	Y ☐ N ☐ Sore throat
Y ☐ N ☐ Bad breath	Y ☐ N ☐ Tooth pain	Y ☐ N ☐ Mass or growth
Y ☐ N ☐ Pain	Y ☐ N ☐ Hoarseness	Y ☐ N ☐ Tongue swelling
Y ☐ N ☐ Voices changes	Y ☐ N ☐ Ear ringing	Y ☐ N ☐ Sinus Pain
Y ☐ N ☐ Post nasal drip	Y ☐ N ☐ Sinus pressure	Y ☐ N ☐ Headache
Y ☐ N ☐ Swollen nodes		
Endocrinology		
Y ☐ N ☐ Excess eating	Y ☐ N ☐ Excess urination	Y ☐ N ☐ Excess thirst
Y ☐ N ☐ Excess sweating	Y ☐ N ☐ Cold intolerance	Y ☐ N ☐ Heat tolerance
Y ☐ N ☐ Fatigue	Y ☐ N ☐ Agitation	Y ☐ N ☐ Weight loss
Y ☐ N ☐ Weight gain	Y ☐ N ☐ Lethargy	Y ☐ N ☐ Insomnia
Y ☐ N ☐ Excess sleeping	Y ☐ N ☐ Hair loss	Y ☐ N ☐ Skin changes
Y ☐ N ☐ Constipation	Y ☐ N ☐ Diarrhea	Y ☐ N ☐ Palpitations
Y ☐ N ☐ Slow heart rate	Y ☐ N ☐ Anorexia	
Respiratory		
Y ☐ N ☐ Dry cough	Y ☐ N ☐ Productive cough	Y ☐ N ☐ Bloody cough
Y ☐ N ☐ ↑ Breath on exert	Y ☐ N ☐ Chest congestion	Y ☐ N ☐ Chest pain
Y ☐ N ☐ Wheezing	Y ☐ N ☐ Positional breath ↓	Y ☐ N ☐ Night breath loss
Y ☐ N ☐ Short of breath		
Urology		
Y ☐ N ☐ Urgency	Y ☐ N ☐ Decreased stream	Y ☐ N ☐ Dribbling
Y ☐ N ☐ Trouble starting	Y ☐ N ☐ Trouble stopping	Y ☐ N ☐ Pain with urination
Y ☐ N ☐ Frequency	Y ☐ N ☐ Hematuria	Y ☐ N ☐ ↓ Urinary control
Y ☐ N ☐ Stones/Sediment	Y ☐ N ☐ Nocturia	Y ☐ N ☐ Testicle mass
Y ☐ N ☐ Testicle pain	Y ☐ N ☐ Scrotal pain	Y ☐ N ☐ Scrotal mass
Y ☐ N ☐ Rash	Y ☐ N ☐ Unable to ejaculate	Y ☐ N ☐ ↓ Ejaculate
Y ☐ N ☐ Bloody ejaculate		
Neurology		
Y ☐ N ☐ Dizziness	Y ☐ N ☐ Gait abnormality	Y ☐ N ☐ Headache
Y ☐ N ☐ Insomnia	Y ☐ N ☐ Memory loss	Y ☐ N ☐ Numbness
Neurology Continued		
Y ☐ N ☐ Seizures	Y ☐ N ☐ Tingling	☐ ☐
Ophthalmology		
Y ☐ N ☐ Halos	Y ☐ N ☐ Floaters	Y ☐ N ☐ Field cuts
Y ☐ N ☐ Vision loss	Y ☐ N ☐ Blurred vision	Y ☐ N ☐ Double vision
Y ☐ N ☐ Red eye(s)	Y ☐ N ☐ Irritated eye(s)	Y ☐ N ☐ Drainage eye(s)
Y ☐ N ☐ Pain in eye(s)	Y ☐ N ☐ Periorbital redness	Y ☐ N ☐ Periorbital swelling
Y ☐ N ☐ Dry eye	Y ☐ N ☐ ↑ Tears in eye(s)	Y ☐ N ☐ ↓ Night vision
Y ☐ N ☐ Photophobia	Y ☐ N ☐ Shifting vision	Y ☐ N ☐ Trouble focusing

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Y ☐ N ☐ Losing near vision	Y ☐ N ☐ Losing far vision	
Hematology/Lymphatics		
Y ☐ N ☐ Swollen glands	Y ☐ N ☐ Swollen nodes	Y ☐ N ☐ Fatigue
Y ☐ N ☐ Malaise	Y ☐ N ☐ New lumps/bumps	Y ☐ N ☐ Anorexia
Y ☐ N ☐ Weight loss	Y ☐ N ☐ Easy bruising	Y ☐ N ☐ Rash
Female Reproduction		
Y ☐ N ☐ Heavy periods	Y ☐ N ☐ Irregular periods	Y ☐ N ☐ Irreg. heavy period
Y ☐ N ☐ No periods	Y ☐ N ☐ Vaginal itch	Y ☐ N ☐ Vaginal discharge
Y ☐ N ☐ Vaginal lesion(s)	Y ☐ N ☐ Pelvic pain	Y ☐ N ☐ Pelvic mass
Y ☐ N ☐ Hot flashes	Y ☐ N ☐ Irritability	Y ☐ N ☐ Painful periods
Y ☐ N ☐ Breast pain	Y ☐ N ☐ Breast mass	Y ☐ N ☐ Nipple discharge
Y ☐ N ☐ Breast rash		
Male Reproduction		
Y ☐ N ☐ Erectile difficulty	Y ☐ N ☐ Penile discharge	Y ☐ N ☐ Painful urination
Y ☐ N ☐ ↓ libido	Y ☐ N ☐ Urgency	Y ☐ N ☐ Frequent urination
Y ☐ N ☐ ↓ ejaculate	Y ☐ N ☐ Bloody ejaculate	Y ☐ N ☐ Testicle pain
Y ☐ N ☐ Testicle mass		
Dermatology		
Y ☐ N ☐ Rash	Y ☐ N ☐ Lumps	Y ☐ N ☐ Bumps
Y ☐ N ☐ Dry skin	Y ☐ N ☐ Scaly skin	Y ☐ N ☐ Bleeding lesion(s)
Y ☐ N ☐ Weeping lesion(s)	Y ☐ N ☐ Oozing lesion(s)	Y ☐ N ☐ Growing lesion(s)
Y ☐ N ☐ Changing lesion(s)	Y ☐ N ☐ Painful lesion(s)	Y ☐ N ☐ Odd color lesion(s)
Y ☐ N ☐ Nail thickening	Y ☐ N ☐ Nail discoloration	Y ☐ N ☐ Nail pallor
Y ☐ N ☐ Itching		
Psychology		
Y ☐ N ☐ Depression	Y ☐ N ☐ Anxiety	Y ☐ N ☐ Agitation
Y ☐ N ☐ Mania	Y ☐ N ☐ Suicidal ideation	Y ☐ N ☐ Want to kill
Y ☐ N ☐ Excessive stressors	Y ☐ N ☐ Paranoia	Y ☐ N ☐ Excess sleep
Y ☐ N ☐ Anorexia	Y ☐ N ☐ Bulimia	Y ☐ N ☐ Mental abuse
Y ☐ N ☐ Hearing voices	Y ☐ N ☐ Seeing things	Y ☐ N ☐ Physical abuse