Date: _____ Patient Identification

Northern Light Mercy Hospital

175 Fore River Parkway, Portland, ME 04102

MERCY PRIMARY CARE CONFIDENTIAL HISTORY

Northern Light Mercy Primary Care
☐ 385 Route One, Yarmouth, ME 04096
☐ 409 Roosevelt Trail, Windham, ME 04062
☐ 74 County Road, South Gorham Crossing, Gorham, ME 04038
☐ 75 Gray Road, Falmouth, ME 04105
☐ 225 Gorham Road, Suite 303, South Portland, ME 04106

Northern Light Mercy Internal Medicine
☐ 43 Baxter Boulevard, Portland, ME 04101

Name: _____ _____ _____
(Last) (First) (M)

Date of Birth: _____/_____/_____ Birth Sex: _____ Gender: _____

Family History

√ Check all that apply	Deceased	Alcohol/Drug Abuse	Cancer (type)	Stroke	Heart Disease	Diabetes	Malignant Moles	Depression	High Blood Pressure	Kidney Disease	Other
Mother											
Father											
Brother											
Sister											
Child											
Grandparent											
Other:											

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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CONFIDENTIAL HISTORY

Personal History:

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

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):

Individuals of Reproductive Age

Age of first period:_____
Periods regular? ☐ Yes ☐ No
How many days between periods?_____
How long is each period? _____
Date you started your last menstrual period?_____
Number of pregnancies?_____
Any miscarriages? ☐ Yes ☐ No
Any Complications? ☐ Yes ☐ No
If yes, please describe _____
Do you use birth control? ☐ Yes ☐ No
If yes, type of birth control used: _____
Date of last Pap Smear: _____
Any history of an abnormal Pap Smear? ☐ Yes ☐ No

Have you had any of the following:

☐ Lumps in testicles
☐ Genital or prostate trouble
☐ Problems with sexual response

Preventative Care

Have you had a Colorectal Screening? ☐ Yes ☐ No
If yes, Date of Exam (best guess) _____
Type of screening: ☐ colonoscopy ☐ Cologuard ☐ other
Name of facility where the screening was done: _____

Have you had a Screening Mammogram? ☐ Yes ☐ No
If yes, Date of Exam (best guess): _____
Name of facility where exam was done: _____

Have you had a Bone Density Scan? ☐ Yes ☐ No
If yes, Date of Exam (best guess) _____
Name of facility where the screening was done: _____

Have you had the following immunizations?
Tetnus/Tdap: ☐ Yes ☐ No If yes, Date received _____
Shingles Vaccine: ☐ Yes ☐ No If yes, Date received _____
COVID Vaccine: ☐ Yes ☐ No If yes, Date received _____
Pneumococcal vaccine: ☐ Yes ☐ No If yes, Date received _____

Describe Briefly Your Present Problem

_____
_____
_____
_____
_____