Main Family Medical

# Patient History Form

**Patient Name:**_____ **Gender:**_____

**Date of Birth:**_____ **Date:**_____

**Home Life (circle): Single Married Domestic Partnership Divorced Widowed**

**Do you have children? (circle one) YES NO**

**How many children?**_____ **How many biological children?**_____

**Employment (circle): Full-Time Part-Time Disabled Retired Homemaker**

**Occupation:**_____

Habits: (complete if applicable):

| | Tobacco Use | Recreational Drugs | Alcohol Intake |
|---|---|---|---|
| **Amount per week:** | | | |
| **Type:** | | | |
| **Did you quit?** | | | |
| **How long ago?** | | | |

**Exercise? Frequency:**_____ **Type:**_____

**Medical History**

**List any <u>current</u> medical conditions:**

_____

_____

**List any <u>past</u> medical conditions:**

_____

_____

**List any surgeries and/or hospitalizations and the year they occurred:**

_____

_____

**Immunizations (If yes, please give approximate year):**

**Pneumococcal**_____ **Zostavax/Shingles**_____ **Tetanus**_____ **Hepatitis A**_____ **Hepatitis B**_____

**Allergies or adverse drug reactions? List drug(s) and type of reaction:**

_____

_____

Current medications (including over the counter and herbal supplements):

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Main Family Medical

# Patient History Form

**Patient Name:**_____ **DOB:**_____

**Family History** (check applicable boxes to identify all illnesses/conditions in your blood relatives)

| | Father | Mother | P. Grandpa | P. Grandma | M. Grandpa | M. Grandma |
|---|---|---|---|---|---|---|
| **Alive/Deceased** (age of death) | | | | | | |
| **Condition** | | | | | | |
| **Alcohol/drug abuse** | | | | | | |
| **Cancer (identify type)** | | | | | | |
| **Depression/Psychiatric** | | | | | | |
| **Diabetes** | | | | | | |
| **Genetic Disorder** | | | | | | |
| **Heart Disease** | | | | | | |
| **High Blood Pressure** | | | | | | |
| **High Cholesterol** | | | | | | |
| **Liver Disease** | | | | | | |
| **Thyroid Disease** | | | | | | |
| **Other** | | | | | | |

**Review of <u>your</u> symptoms:**

**Gastrointestinal**
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease/abnormal liver tests

**Cardiovascular**
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular heartbeat
- ☐ history of poor circulation

**Pulmonary/lungs**
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

**Muscle/joint/bone**
- ☐ swelling of ankles or legs

*pain, weakness or numbness in*
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

**Neurologic**
- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ numbness or tingling in limbs
- ☐ migraine headaches

**Eyes, ears, nose, throat**
- ☐ blurred vision/change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

**Genitourinary**
- ☐ frequent or painful urination
- ☐ blood in urine

**Skin**
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

**Endocrine**
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

**General**
- ☐ weight gain/loss of 10+ lbs (past 6 months)
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Women Only: Date of last mammogram:_____Date of last pap:_____ Date of last menses:_____