Main Family Medical

Patient History Form

Patient Legal 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 Sons?_____ **How many daughters?** _____ **How many biological children?**_____

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

Occupation:_____

Current medications (including over the counter and herbal supplements): **Bring all bottles**

Medication	Dose	Frequency

Medical History

List any current medical conditions:

_____

_____

_____

List any past medical conditions:

_____

_____

_____

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

_____

_____

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

_____

Habits: (complete if applicable):

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

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

Main Family Medical

Patient History Form

Patient Legal 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	Brother(s)	Sister (s)
Alive – DOB/Age								
Deceased (age of death)								
Alcohol/drug abuse								
Cancer (identify type)								
Depression/Psychiatric								
Diabetes								
Genetic Disorder								
Heart Disease								
High Blood Pressure								
Thyroid Disease								
Other								

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

<u>CONSTITUTIONAL:</u>
- weight gain
- weight loss
- loss of appetite
- fever
- weakness
- history of stroke
- history of angina or heart attack
- history of high blood pressure
- history of thyroid disease

<u>OPTHALMOLOGY:</u>
- drainage from eyes
- blurring of vision
- visual changes yes

<u>ENT:</u>
- coughing blood
- nose bleed
- hearing loss
- change in voice
- sore throat
- ringing in ears
- snoring

<u>ENDOCRINOLOGY:</u>
- fatigue
- excessive sweating
- excessive thirst
- excessive urination

<u>CARDIOLOGY:</u>
- chest pains
- palpitations
- leg swelling

<u>GASTROENTEROLOGY:</u>
- difficulty swallowing
- abdominal pain
- nausea/vomiting
- constipation
- diarrhea
- blood in stool
- change in bowel habits

<u>DERMATOLOGY:</u>
- rash
- change in color of moles

<u>NEUROLOGY:</u>
- headache
- tingling numbness
- seizures
- dizziness

<u>MUSCULOSKELETAL:</u>
- joint swelling
- joint pain
- leg cramps
- joint stiffness

<u>PSYCHOLOGY:</u>
- high stress level normal
- depression
- sleep disturbances

<u>RESPIRATORY:</u>
- shortness of breath
- persistent cough
- history of asthma
- history of COPD

Women Only:

Date of last mammogram? _____

Date of last pap? _____

Date of last menses? _____

Do we manage your GYN care Yes___No_____

If no who do you see? _____

Any other concerns?

_____

_____

_____

_____