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?

_____

_____

_____

_____