The Family Health Center, P.C.

Name _____ Date of Birth _____

Single/Married/Divorced/Widow(er) Age _____ Occupation _____

***PERSONAL HISTORY**: Have you ever had?*

Acid Reflux	Yes	No		Hemorrhoids	Yes	No
AIDS	Yes	No		Hepatitis	Yes	No
Alcoholism	Yes	No		Hernia	Yes	No
Anemia	Yes	No		High Blood Pressure	Yes	No
Anxiety	Yes	No		High Cholesterol	Yes	No
Arthritis	Yes	No		Intestinal Disease	Yes	No
Asthma	Yes	No		Kidney Stone	Yes	No
Attention Deficit Disorder	Yes	No		Liver Disease	Yes	No
Attention Deficit Hyperactivity Disorder	Yes	No		Migraine	Yes	No
Blood Clots in legs or lungs	Yes	No		Osteoporosis	Yes	No
Cancer	Yes	No		Pneumonia	Yes	No
Concussion/Head Injury	Yes	No		Psoriasis	Yes	No
Chronic Lung Disease	Yes	No		Received a blood transfusion	Yes	No
Depression	Yes	No		Seizures	Yes	No
Diabetes	Yes	No		Sleeping Problems	Yes	No
Eczema	Yes	No		Stroke	Yes	No
Fracture (if so, where)	Yes	No		Thyroid Problems	Yes	No
Gallbladder Disease	Yes	No		Tuberculosis	Yes	No
Glaucoma	Yes	No		Ulcer	Yes	No
Gout	Yes	No		Varicose Veins	Yes	No
Heart Disease	Yes	No		Urinary Incontinence/Leaking Urine	Yes	No
Female				***Male***		
Age of first period				Circumcised		
Date of last period				Difficulty with Erection		
Date of last mammogram				Difficulty with Ejaculation		
Date of last pelvic exam				Difficulty Urinating		
How many times have you been pregnant?				History of sexually transmitted disease?		
How many live births				Leaking urine		
How many Cesarean births				Painful urination		
Do you use birth control?	Yes	No		Other urination problems		
Ever had an abnormal Pap?				Weak stream		
History of sexually transmitted disease?						
Lifestyle/Preventive Health Care:				*Lifestyle/Preventive Health Care (cont)*		
Do you get regular exercise?	Yes	No		Have you ever had Bone Density Test	Yes	No
Do you smoke?	Yes	No		If so, when?		
If so, how much				Do you drink alcohol?	Yes	No
Glasses	Yes	No		If so, how much		
Wear Contacts	Yes	No		Date of lat Colonoscopy		
Have you ever had:				Date of last Dental Exam		
Pneumonia Vaccine	Yes	No		Date of last Eye Exam		
Shingles Vaccine	Yes	No		Date of last Physical Exam		
Date of last Tetanus Vaccine						

FAMILY HISTORY

Please specify what relative (mother, grandfather, uncle, etc) had illness below

Cancer	
Diabetes	
Stroke	
Epilepsy	
Tuberculosis	
Heart Trouble	
High Blood Pressure	

Medications (Please list all medications including over-the-counter, vitamins, herbals, supplements),

Medication and Dose	Times Taken	Reason for Taking

List all surgeries you've ever had:

_____
_____
_____
_____

Allergies to Medication, food, or environmental, and type type of reaction you have:

Allergy	Reaction

Is there anything else about your medical history you think we should know? (Please print response)

Patient Signature _____ Date _____

Provider Signature _____ Date _____