Family Health Center

PATIENT HISTORY FORM
Note: Please bring completed form at time of visit along with medical record (that is, most recent labs, x-rays, and visit note) from previous doctor.

LAST NAME ________________________ FIRST NAME:___________________

DATE OF BIRTH: ___ /_____/_____ AGE___ SEX: ______

TODAY'S DATE ______/_____/_____

Reason for Visit
____
____

Major Illnesses . Patient Only (Please check all that apply)

ˇ	Asthma	ˇ	Pneumonia	ˇ	Chronic Lung Disease	ˇ	Kidney Disease
ˇ	Tuberculosis	ˇ	Sexually Transmitted Disease	ˇ	Heart Disease/Murmur	ˇ	Diabetes
ˇ	Cancer	ˇ	Stroke	ˇ	Rheumatic Fever	ˇ	High Blood Pressure
ˇ	Ulcers	ˇ	Depression/Anxiety	ˇ	Anemia/Blood Transfusion	ˇ	Seizures
ˇ	Glaucoma	ˇ	Arthritis/Joint Pain	ˇ	Osteoporosis	ˇ	Bowel Problems
ˇ	Hepatitis	ˇ	Bone Fracture	ˇ	Thyroid Disorder	ˇ	Abnormal PAP
ˇ	Auto Immune	ˇ	Muscular/Neurological Disorders	ˇ	Skin Disorders	ˇ	Other

Medicines – Bring in all medications containers (Over-the-counter/vitamins/herbs and prescribed medicines.)

Allergies to medications? None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Medication	Reaction

Surgeries/Hospitalizations/Injuries (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

Social History

Last Annual Physical _______________
Special Diet ________________
Number of alcoholic beverages daily _________ weekly __________
Tobacco use: yes no how much _________
Street Drug use: if yes what_______________________
Number of times weekly exercise ___________
Last mammogram ____________ last pap_____________
Last rectal _________ last Chest X-ray _________
Last colonoscopy/endoscopy and which physician ______________________
Diagnostic imaging (MRI, CAT scan, PET scan, Echocardiogram, Ultrasound) with outcome and dates:
____
____

Last tetanus ________ Last flu shot __________
Last pneumonia vaccine ____________
Zostivax (shingles) vacc: yes no Gardasil vacc (3 series): yes no

Any Other Doctors Involved in Care
____
____
____
____
____

Marital Status: Married Single Divorced Widowed

Occupation ___________________________

Highest Level of Education__________________

Number of Children _______________

Pregnancies_______________

Last Menstrual Cycle____________