Family Medicine PC

Health History Form · Please Give To Nurse When Called

Name: **Today's Date:**

Present Illness (A brief description of your present complaint)

Date issue started:

Surgical History (Please Check All That Apply)

☐ Eye Surgery	☐ Parathyroid Surg.	☐ Mastectomy	☐ D&C	☐ Orthopedic Surg
☐ Adenoidectomy	☐ Heart Surgery	☐ Abdominal Surg	☐ Cesarean Section	☐ Spinal Surgery
☐ Tonsillectomy	☐ Heart Valve Repair	☐ Hernia Repair	☐ Tubal Ligation	☐ Prostate Surgery
☐ Sinus Surgery	☐ Abdominal Aortic Aneur	☐ Appendix Removal	☐ Tubes Removed	☐ **No Prior Surgery**
☐ Thyroid Surg.	☐ Breast Lumpectomy	☐ Gall Bladder Removal	☐ Hysterectomy	

☐ Other:

Personal Medical History

☐ Headache/Migraine	☐ COPD	☐ Reflux	☐ Kidney Stones	☐ Anxiety
☐ Epilepsy	☐ Pneumonia	☐ Peptic Ulcer	☐ Bladder Disorder	☐ Depression
☐ Glaucoma	☐ Tuberculosis	☐ Hepatitis	☐ Prostate Disorder	☐ Cancer
☐ Pituitary/Hypothalmic	☐ Sleep Apnea	☐ Gallstones	☐ Venereal Disease	☐ HIV
☐ Allerg.Rhinitis/Hayfever	☐ Hypertension	☐ Pancreatitis	☐ Arthritis	☐ Hyperlipidemia
☐ Chronic Sinusitis	☐ Angina (Chest Pain)	☐ Diabetes Mellitus	☐ Osteoporosis	
☐ Thyroid Disorders	☐ Peripheral Vasc Dis.	☐ Adrenal Disorder	☐ Easy Bleeding	
☐ Asthma	☐ Heart Disorders	☐ Renal Disorders	☐ Anemia	

☐ Other:

☐ Yes - ☐ No Have you had a blood transfusion? When? Where? Reaction?

☐ Yes - ☐ No Previous Hospitalizations

Previous Tests (Include Date)

☐ EKG:	☐ Breathing Tests:	☐ Mammogram:	☐ Test For Stool Blood:	☐ Cholesterol:
☐ Chest X-Ray:	☐ Blood Tests:	☐ Prostate Exam:	☐ Echocardiogram	☐ Cardio Stress Tes
☐ Colonoscopy				

Allergies / Reactions

☐ Penicillin	☐ Cephalosporin	☐ Tetracycline	☐ NSAIDS	☐ Anesthetics
☐ Bandaging Tape	☐ Sulfa Drugs	☐ Aspirin	☐ Narcotics	☐ Latex
☐ Contrast Material - Iodine	☐ Yes - ☐ No Other			

Immunizations (Include Date)

☐ Flu	☐ Pneumovax	☐ Tetanus	☐ Hep B	☐ PPD (Tuberculosis Test)
☐ DTP	☐ Meningococcal			

Marital Status

☐ Single	☐ Married, Yrs:	☐ Separated	☐ Widowed	☐ Divorced

Social History (Check All That Apply)

☐ Alcohol Use	☐ Do You Smoke?	☐ Caffeine Use	Cups of Tea/Day	☐ Regular Exercise
Drinks per day:	Cigarette packs per day:	Cups Of Coffee/Day:	☐ Recreational Drug Use	

Family History

Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hemophilia A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Other

☐ Adopted: Family History Unavailable

Women's History

Last Period	☐ Light Bleeding	Flow Duration	☐ Regular Cycles	Last Pap Smear:
Pads used in 24hr:	☐ Heavy Bleeding	Age of first period:	☐ Irregular Cycles	☐ Past Abnormal Pap
☐ Tampon use	Pregnancies (Gravid):	Deliveries (Para):		☐ Menopause

Current Medications

Name	Dose	Frequency

Revised: 7.14.2010

Signature _____ Date _____