Patient History Form

Name: ______________________________ Date: ______________

Gender: M or F Date of Birth: __________ Age:______

What name would you like to be called? ______________________________

How were you referred to Family First Physicians? ______________________________

Please state reason for today's visit: ______________________________

TELL US ABOUT YOURSELF:

Marital Status: ______________

Children: Yes or No How many: ______ Are they healthy?______________________________

Occupation: ______________________________

Do you exercise: Yes or No If yes, what type and how often? ______________________________

Habits:

Do you smoke? Yes or No
If yes, how many packs per day?______________
If yes, how long have you smoked?______________
If you have quit, how long ago?______________

Any exposure to second-hand smoke? Yes or No
If yes, who smokes? ______________

Do you dip or chew tobacco? Yes or No
If yes, how much? ______________
If you have quit, how long ago? ______________

Do you use alcohol? Yes or No
If yes, how often and how much do you drink?______________
If you have quit, how long ago?______________

Do you use drugs? Yes or No
Have you ever had problems with drug use?______________

Do you drink caffeine? Yes or No
If yes, what type and how much? ______________

Specialists:

Do you see a dentist? Yes or No Last visit date: ______________________________

Do you see an eye doctor? Yes or No Last visit date: ______________________________

Do you see any other physicians or medical providers? Yes or No Last visit date: ______________
Name: ______________ Reason for visit: ______________
Name: ______________ Reason for visit: ______________

Health Maintenance Tests:

Have you had any of the following? If so, where, approximate date and outcome:

EGD (Upper Endoscopy): ______________Stool Occult Blood Test: ______________

Colonoscopy: ______________ Bone Desity Test: ______________

Men only:

Prostate Exam: ______________ PSA (Prostate specific antigen): ______________

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PAST MEDICAL HISTORY:

CURRENT DISEASES (e.g. high blood pressure, diabetes, asthma, high cholesterol, thyroid disease, etc.):

Disease	First Diagnosed (Month/Year)	Treated By (Specialist's Name)

PAST DISEASES OR SERIOUS ILLNESSES:

Disease/Illness	Date Resolved (Month/Year)	Treated By (Specialist's Name)

SURGERIES:

Surgery	Reason for the Surgery	Date of Surgery (month/year)

MEDICATIONS:

Name	Strength and Dose	How often taken

NON-PRESCRIPTION: (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, supplements, etc.)

Name	Strength and Dose	How often taken

HERBAL PREPARATIONS or HOMEOPATHIC REMEDIES:

Name	Strength and Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS?

Medication Name	Type of Reaction	When

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FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives. Place "XX" in appropriate box to identify deceased individuals.

Illness/Condition	**Family Member**							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

IMMUNIZATION HISTORY: (Patients over the age of 18)
Pneumococcal (Pneumovax) No_________ Yes__________ Date: ______________________
Tetanus (DT or Tdap) No_________ Yes__________ Date: ______________________
Influenza No_________ Yes__________ Date: ______________________
Zostavax (Shingles) No_________ Yes__________ Date:______________________

REVIEW OF SYSTEMS (CURRENT SYMPTOMS):

General	**Yes**	**No**	**If yes, explain and date symptoms first started**
Fever or Chills			
Sweats			
Change in Sleep Habits			
Weight Change			
Pain			
Fatigue			
Hearing Loss			
Vision Changes			
Psychological			
Anxiety			
Depression			
Other			
Neurological			
Memory Changes			
Dizziness/Fainting			
Blurred Vision			
Numbness/Tingling			
Headache			
Head & Neck			
Nose Bleeds			
Problems Swallowing			
Lesions in Mouth			
Sore Throat			
Cardiovascular			
Leg Pain or Swelling			

Patient History Form

Increased Heart Beat			
Chest Pain			
Increased Blood Pressure			
Palpitations			
Respiratory			
Wheezing			
Shortness of Breath			
Cough			
Asthma			
Emphysema/COPD			
Bloody Phlegm			
Breast			
Lumps			
Changes			
Pain			
Nipple Discharge			
Gastrointestinal			
Constipation			
Blood in Stools			
Indigestion			
Nausea or Vomiting			
Reflux or Heartburn			
Change in Appetite			
Abdominal Pain			
Diarrhea			
Black Stools			
Irritable Bowel Syndrome			
Genitourinary			
Burning with Urination			
Blood in Urine			
Unable to Control Bladder			
Frequency			
Dribbling			
Recurrent Infections			
Musculoskeletal			
Swelling			
Joint or Back Pain			
Arthritis			
Skin			
Open Sore			
Changes in Moles			
Rashes			
Endocrine			
Cold Intolerance			
Hot Flashes			
Diabetes/Elevated Blood Sugar			
Thyroid Abnormalities			
Other			

Patient History Form

WOMEN ONLY

Age Periods Began:_______________ First Day of Last Menstrual Period:______________

Periods at Present:
How Often: ______________ How Many Days: _____________ Flow: (circle) Light Moderate Heavy
Pain with Periods: Yes or No

Menopausal Symptoms: Yes or No Menopausal Symptoms: (circle) Hot Flashes Night Sweats Problems Sleeping

Date of Last Pap: __________________ Results: ____

Have you ever had an abnormal pap smear? Yes or No If yes, what type of abnormality? ____________________
Treatment: ______________________________ Date (Month/Year): _____________________

Have you ever been treated for the following sexually transmitted diseases? (circle all that apply)

Syphillis Gonorrhea Chlamydia Herpes Genital Warts

How was it treated? ____

Date of Last Mammogram: _________________ Results:____

Pregnancies:
Live Births:

Date	Type of Delivery	Anesthesia	Length of Pregnancy	Infant Weight	Complications

Children's Ages: ____

Other Pregnancies:

Date	Length of Pregnancy	Complications/Outcome

Family Planning:
What type of contraception, if any, are you using? (Circle all that apply)
Birth Control Pills (Name) ________________ Depo-Provera IUD (date inserted) _______________
Diaphragm Condoms Tubal Ligation (date) ____________ Vasectomy Other______________ None

Breastfeeding:
Are you currently breastfeeding? Yes or No
Have you breastfed in the past? Yes or No