MEDICAL HISTORY Family Medical Care

NAME: First MI Last _____ **Date of Birth**

Single Married/Partner Divorced Widower (circle one)

Education (yrs): High School _____
College _____ Other _____
Occupation: _____

HEIGHT_____ WEIGHT_____ WT at age 20_____ WT (gain/loss) in past year_____ Desired Weight_____
DATE OF LAST: tetanus shot____ flu shot____ physcial____ dental exam____ pap smear____ mammogram____

SURGERIES (circle)	DATE
hysterectomy	_____
hernia	_____
gallbladder	_____
appendectomy	_____
breast surgery	_____
c-section	_____
other_____	_____

ILLNESSES / INJURIES (circle)

hypertension	glaucoma
diabetes	thyroid
epilepsy	substance abuse
asthma/allergies	domestic violence
heart attack/stroke	bladder/kidney problem
depression/anxiety	ulcer/stomach problem
hepatitis (A,B,C)	accidents_____
cancer_____	other_____

ALLERGIES: _____

FAMILY HISTORY	Age	Age at Death / Cause
Father	_____	_____
Mother	_____	_____
Brother/Sister	_____	_____
	_____	_____
	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
	_____	_____

WHO LIVES IN YOUR HOUSEHOLD?_____

HAS ANY BLOOD RELATIVE EVER HAD:
(Specify who)

asthma/allergies	_____
glaucoma	_____
cancer/type	_____
diabetes	_____
heart trouble	_____
high blood pressure	_____
stroke	_____
substance abuse	_____
thyroid problem	_____
colon cancer/colitis	_____
ulcers/stomach trouble	_____

HABITS (Circle all that apply)
ALCOHOLIC DRINKS:
never 1-2 per month 1-2 per week
1-2 daily 3 or more daily
CIGARETTES: _____packs per day
cigars pipes chewing tobacco snuff
year quit _____ # yrs smoked _____
COFFEE / TEA / SODA: _____ per day

DRUGS USED: (now / past)
marijuana cocaine heroine speed
other_____
EXERCISE:
Type _____
days per week ____ minutes per day _____

PRESCRIPTION MEDS & DOSAGES:

_____
_____
_____
_____
_____
_____
_____

NON-PRESCRIPTION DRUGS, VITAMINS, HERBS, ETC

_____
_____
_____
_____
_____
_____
_____

Please Complete Both Pages of Form. Thank You!

CURRENT PROBLEMS OR CONCERNS: (How long has this been a problem)

_____

_____

_____

BODY SYSTEMS REVIEW: (Check any item that you are experiencing to any significant degree)

_____ unexplainable fatigue
_____ recurring fever/chills
_____ swollen glands
_____ night sweats
_____ weakness
_____ weight problem

_____ unconciousness
_____ frequent/severe headaches
_____ fainting
_____ dizzy spells
_____ seizures
_____ head injury
_____ paralysis

_____ trouble concentrating
_____ memory problems
_____ tense/irritable
_____ trouble sleeping
_____ feel depressed
_____ work or family problems
_____ thoughts about suicide
_____ seeing a counselor

_____ knee/ankle problem
_____ shoulder/elbow problem
_____ arthritis/joint pains
_____ back/neck trouble
_____ numbness/tingling

_____ chronic cough
_____ cough blood
_____ pneumonia
_____ short of breath
_____ wheezing

_____ chest pain
_____ heart murmer
_____ palpitations
_____ rheumatic fever
_____ swollen ankles/feet
_____ leg pain with walking
_____ varicose veins
_____ blood clots
_____ anemia
_____ blood disease

_____ bladder/kidney infection
_____ difficulty unrinating
_____ frequent urination
_____ leaking urine
_____ kidney stone
_____ infertility
_____ sexual difficulties
_____ prostate problems
_____ penile discharge
_____ lump on testicle
urinate at night_____time(s)

_____ heartburn
_____ ulcer
_____ irritable bowel
_____ black or bloody stools
_____ rectal bleeding
_____ abdominal pain
_____ constipation/diarrhea
_____ loss of appetite
_____ change in bowel habits
hemorrhoids

_____ psoriasis
_____ eczema
_____ changing moles
_____ skin cancer

_____ ear/hearing problem
_____ eye/vision problem
_____ glaucoma
_____ cataracts
_____ seasonal allergies
_____ sinus trouble
_____ dental problems
_____ persistent hoarseness
_____ trouble swallowing
_____ thyroid problem

WOMEN ONLY: Menstrual History

age of onset _____
length of cycle _____
days of flow _____
days of last period _____
periods painful? _____
unusual discharge? _____

painful intercourse? _____
previous sexual abuse? _____
do you perform self breast exam? _____
breast lump or cyst? _____
menopausal symptoms? _____
taking/taken hormones? _____

number of pregnancies _____
number of children _____
type of birth control you use _____
history of abnormal pap? _____

family history of osteoporosis / breast / cervical / uterine cancer? _____

NUTRITION: HOW MANY SERVINGS OF THE FOLLOWING FOODS DO YOU EAT?

PER DAY: meals____ snacks____ total cups of fluids____ cups of milk____
breads & starches____ fruits & vegetables____

PER WEEK: eggs____ red meats____ cheeses____ fish____ fried foods____
desserts____ chips / snack foods____

SIGNATURE_____ **DATE**_____