FAMILY MEDICAL CENTER

FAMILY PRACTICE

Name ______ SS# ______ Date ______

Address ______ Occupation ______

Phone (home) ______ (work) ______ Date of birth ______ Age ______

Chief complaint ______

DRUG ALLERGIES

______

______

______

______

______

CURRENT MEDS

______

______

______

______

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEDICAL HISTORY

❑ Headache ______
❑ Shortness of breath ______
❑ Heart palpitations ______
❑ Heart murmur ______
❑ Chest pain ______
❑ Dizziness/Fainting ______
❑ Peripheral vascular disease ______
❑ Allergies/Hay fever ______
❑ Asthma ______
❑ Bronchitis ______
❑ Pneumonia ______
❑ Ulcer ______
❑ GI disorder ______

❑ Lactose intolerance ______
❑ Gallbladder disease ______
❑ Prostate disease ______
❑ Bowel irregularity ______
❑ Incontinence ______
❑ Sexual/menstrual dysfunction ______
❑ Venereal disease ______
❑ Frequent infections ______
❑ Hepatitis ______
❑ Anemia ______
❑ Arthritis ______
❑ Osteoporosis ______
❑ Nervousness ______

❑ Depression ______
❑ Gout ______
❑ Scarlet fever ______
❑ Chronic rashes ______
❑ Rheumatic fever ______
❑ Mumps ______
❑ Measles ______
❑ Rubella ______
❑ Polio ______
❑ Diphtheria ______
nus ______
❑ Other ______
❑ Other ______

HABITS

❑ Smoke: Packs daily ______
How long? ______
Interested in stopping? ______

❑ Exercise routine: ______

______

❑ Coffee: Cups daily ______
Other caffeine ______

❑ Alcohol: Type ______
Amount ______

❑ Diet: Salt intake ______
Fat intake ______

❑ Sleep: Difficulty falling asleep ______
Continuity disturbances ______
Snoring ______
Early morning awakening ______
Daytime drowsiness ______
Other ______

Hepatitis C risk factor

❑ Blood transfusion prior to 1992
❑ IV drug use (1+ times)
❑ Contact with blood/bodily fluid
❑ Tattoos
❑ Shared razor/toothbrush
❑ Body piercing

Name ______

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