

FAMILY HEALTH PATIENT HISTORY FORM

Date _____

Name _____ DOB _____ SEX F M

Marital Status S M W D Occupation _____ Children _____

Medication:
Dosage
include
over the
counter
drugs

ALLERGIES: Reaction _____

MEDICAL HISTORY

Please indicate if you have had any of the following conditions

System	Yes	NO	System	YES	NO	System	YES	NO
High Blood Pressure			Hoarseness			Kidney Stones		
Chest Pain			Pneumonia			Bleeding Disorder		
Heart Attack			Shortness of Breath			Arthritis		
Irregular Heartbeat			Tuberculosis			Back Pain		
Rheumatic Fever			Diarrhea			Muscle Disease		
High Cholesterol			Constipation			Glaucoma		
Diabetes			Weight Loss			Cataracts		
Thyroid Disorder			Hepatitis			Alcoholism/drug use		
Stroke			Heartburn			Anxiety		
Seizures			Liver Disease			Depression		
Migraines			Rectal Bleeding			Sexual Dysfunction		
Asthma			Blood in Urine			AIDS/HIV		
Chronic Cough			Cancer : type					

Regular Exercise days/wk _____

Smoking History: NEVER CURRENT FORMER #pk/day _____ # years _____ QUIT _____

Number Alcoholic Beverages Consumed: week _____ month _____

Use of recreational/illicit drugs: NEVER CURRENT FORMER kind/how long _____

SURGERIES/HOSPITALIZATIONS

date

date

PREVENTIVE HEALTH

Regular seatbelt use NO Yes
Last Eye Exam _____

Last Colonoscopy _____
Last Mammogram _____

FAMILY HISTORY

Please indicate if your parent, grandparent, brother, sister and/or children have had any of the following

Heart Disease		Bleeding Disorder		Asthma	
Diabetes		Thyroid Disorder			
Cancer: Type _____					

Person completing this form _____

Reviewed by Provider _____ Date _____