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/HOSPITAIZATIONS	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