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Family Practice
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Date: _____/_____/_____

PATIENT HISTORY FORM

NAME: _____ DATE OF BIRTH _____/_____/_____

REASON FOR THE VISIT _____ REFERRING DOCTOR _____

MEDICATIONS

Please list all current medications, including Vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

PAST MEDICAL HISTORY

Please check whether you have or had any of the following conditions and the year diagnosed if possible:

	YES	NO
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation		
Autoimmune Disease		
Bipolar Disorder		
Breast Cancer		
Cancer		
Cardiovascular		
Celiac Disease		
CHF		
Clotting Disorder		
Colon Cancer		

	YES	NO
COPD		
Dementia		
Depression		
Diabetes Mellitus		
Eye Disease		
Glaucoma		
Gout		
Heart Murmur		
Hepatitis A		
Hepatitis B		
High Blood Pressure		
High Cholesterol		
HIV		
Kidney Disease		
Kidney Stones		

	YES	NO
Lung Cancer		
Migraines		
Myocardial Infarctions		
Nerve/Muscle Disease		
Osteoporosis		
Prostate Cancer		
Seizures		
Skin Cancer		
Sleep Apnea		
Stroke		
Substance Abuse		
Thyroid Disease		
Tremors		
Others:		

SURGICAL HISTORY

Please list all prior surgeries:

	Y / N	Year
Appendectomy		
Brain Surgery		
Breast Surgery		
CABG		
Cholecystectomy		
Colon Surgery		
Cosmetic Surgery		
C-Section		
Dental Surgery		

	Y / N	Year
Ear Tubes		
Eye Surgery		
Foot Surgery		
Fracture Surgery		
Hernia Repair		
Hysterectomy		
Joint Replacement		
Ovary Removal		
Prostate Surgery		

	Y / N	Year
Small Intestine Surgery		
Spine Surgery		
Thyroid Surgery		
Tonsillectomy		
Tubal Ligation		
Valve Replacement		
Vasectomy		
Vein Surgery		
Others:		

FAMILY HISTORY

Please answer the following questions about your family members:

Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Sister 1	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Sister2	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Brother 1	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Brother 2	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Family History	Please list any significant medical problems of other relatives: (e.g., grandparents, uncles, aunts, etc.)		

SOCIAL HISTORY

Tell us about yourself

Home life	☐ Single ☐ Married ☐Divorced ☐ Widowed ☐Domestic Partnership
	Children? ☐ Yes ☐ No Are they healthy?
Employment	Status: ☐Full time ☐Part-time ☐Retired ☐Disabled ☐Homemaker ☐Other _____
	Occupation (past or present) / type of work:
Tobacco Use	Do you smoke ? ☐Yes ☐No If yes, how many packs per day?
	How many years did you smoke? / What year did you quit?
Drinks Alcohol	Do you drink alcohol ? ☐Yes ☐No If yes, how often ? Daily --Weekly --Monthly --Socially --Rarely
	☐Beer ☐Wine ☐Liquor Amount? When was your last drink?
Drug Use	Do you currently use recreational drugs ? ☐Yes ☐No Have you in the past?☐Yes ☐No
	Have you ever used intravenous drugs ? ☐Yes ☐No
Caffeine Use	If yes, what kind ? Please circle : Coffee --- Soda --- Chocolate --- Tea --- Other ?
	How many cups ? How many sodas?
Miscellaneous	Have you ever received a blood transfusion ? ☐Yes ☐No
	Do you use seatbelts ? ☐Yes ☐No Do you have a smoke detector in your home ? ☐Yes ☐No

PHARMACY INFORMATION

Pharmacy 1 (Local)	Name :
	Address :
Pharmacy 2 (Mail Order)	Name :
	Address :

Reviewed by MD and discussed with patient _____

REVIEW OF SYSTEMS
Please Check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

Fever	☐Yes☐No
Headache	☐Yes☐No
Unexplained weight loss	☐Yes☐No

Other :

Neurologic / Psychiatric

Numbness	☐Yes☐No
Tingling	☐Yes☐No
Weakness	☐Yes☐No
Dizziness	☐Yes☐No
Memory loss	☐Yes☐No
Seizures	☐Yes☐No
Anxiety	☐Yes☐No
Spinal cord injury	☐Yes☐No
Headache	☐Yes☐No
Difficulty Sleeping	☐Yes☐No

Other :

Respiratory

Shortness of breath	☐Yes☐No
Wheezing	☐Yes☐No
Cough	☐Yes☐No

Other :

Cardiovascular

Chest Pain	☐Yes☐No
Irregular pulse	☐Yes☐No
Heart Attack	☐Yes☐No
Heart valve problem	☐Yes☐No

Other:

Gastrointestinal

Abdominal pain	☐Yes☐No
Nausea / vomiting	☐Yes☐No
Indigestion / Heartburn	☐Yes☐No
Diarrhea	☐Yes☐No
Constipation	☐Yes☐No

Other :

HEENT

Runny nose	☐Yes☐No
Difficulty hearing	☐Yes☐No
Other :	☐Yes☐No

Metabolic / Endocrine

Excessive thirst	☐Yes☐No
Too hot	☐Yes☐No
Too cold	☐Yes☐No

Other :

Immunologic:

Hay fever	☐Yes☐No
Food allergies	☐Yes☐No

Other :

Musculoskeletal

Joint Pain	☐Yes☐No
Back Pain	☐Yes☐No
Artificial joints	☐Yes☐No

Other :

Hematologic

Easy bruising or bleeding	☐Yes☐No
Blood clots in arms or legs	☐Yes☐No
Anemia	☐Yes☐No

Other :

Genitourinary

Back Pain	☐Yes☐No
Cloudy urine	☐Yes☐No
Frequent night time urination	☐Yes☐No

Other :

Dermatologic

Rash	☐Yes☐No
Boils / infections	☐Yes☐No
Abnormal pigmentation	☐Yes☐No

Other :

Vascular

Cool Extremity	☐Yes☐No
Pain in limb	☐Yes☐No
Varicose Veins	☐Yes☐No

Other :

Reviewed by MD & discussed with patient _____