Personal and Family History

Name _____ Date of Birth_____ Social Security #_____

Preferred Language_____ Race_____

Allergies: _____

_____

_____

Past Medical History

- ❑Asthma
- ❑Bronchitis
- ❑Cancer, Type_____
- ❑Diabetes
- ❑Gout
- ❑Heart Disease
- ❑Hernia
- ❑High Cholesterol
- ❑HIV
- ❑ HTN
- ❑Kidney Disease
- ❑Liver Disease
- ❑Migraine Headaches
- ❑Pacemaker
- ❑Pneumonia
- ❑Prostate Problems
- ❑Stroke
- ❑Thyroid Problems
- ❑Reflux
- ❑Recurring Urinary Problems
- ❑Vaginal Infections

Other History:

_____

_____

_____

_____

Past Surgeries

- ❑Appendectomy
- ❑Gall Bladder
- ❑Colectomy
- ❑Hemorrhoidectomy
- ❑Hernia repair
- ❑Oncology surgery
- ❑Hysterectomy

Other Surgeries:

_____

_____

_____

_____

Family History

Father
- ❑Alive
- ❑Deceased at age ___

Mother
- ❑Alive
- ❑Deceased at age ___

Please List Family Members with the Following Conditions

Arthritis_____
Asthma_____
Cancer _____
Diabetes_____
Heart Disease_____
High Blood Pressure_____
Migraines_____
Stroke _____

Social History

Tobacco Use

- ❑ Never
- ❑ Currently, What type and how long? _____

_____

- ❑ Quit, how long?_____

Alcohol Use

- ❑ Never
- ❑ Yes, how often?_____

Illicit Drug Use

- ❑ Never
- ❑ Yes, list type(s)_____

_____

Marital Status

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

Numbers of Others in Home ____

Pharmacy Preference

*Name*_____

*Location*_____

_____

_____

Problems

List all ongoing problems

_____

_____

_____

_____

_____

_____

_____

Other Physicians

List all other physicians you see

_____

_____

_____

Screenings

- ❑Colonoscopy Date _____
- ❑Mammogram Date_____
- ❑Glaucoma Date _____
- ❑Pap-Smear Date_____
- ❑Bone Density Date_____

Vaccine History

Tetanus Date_____
Flu Date_____
Pneumonia Date_____
Shingles Date_____

Routine Medications

Prescription (list strength)

_____

_____

_____

_____

_____

_____

_____

Over the Counter Medicine/ Vitamins/Supplements

_____

_____

_____

_____

Patient Signature_____ Date_____