# The Family Physicians Group - Medical History Form

**Date**_____/_____/_____

**Name**_____ male female **Birthdate**____/____/_____ **Age**____ S M D W
**Address**_____ **City**_____ **State**_____ **Zip**_____
**Phone Numbers: (H)**_____ **(O)**_____ **(Cell)**_____
**Occupation**_____ **Company**_____

## Your Past History: *Have YOU ever had any of these conditions? If so, when? Please write approximate year or age.*

- ❑ Heart Bypass Surgery
- ❑ Angioplasty/Stents
- ❑ Heart attack
- ❑ Stroke
- ❑ Diabetes
- ❑ High Cholesterol

- ❑ High Blood Pressure
- ❑ Blood Clots
- ❑ Easy Bleeding
- ❑ Abnormal Pap
- ❑ Pregnancy #____ Births #___ Miscarriage #___ Abortion #___

- ❑ Anemia
- ❑ Stomach Ulcer
- ❑ Asthma
- ❑ Depression
- ❑ Suicide Attempt
- ❑ Alcohol/Drug Dependency
- ❑ Osteoporosis

- ❑ Gout
- ❑ Migraines
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Glaucoma
- ❑ Colon Polyps
- ❑ Seizures

**Cancer/Type:**
- ❑ Colon
- ❑ Breast
- ❑ Prostate
- ❑ Lung
- ❑ Other

***Other Medical Conditions You Have or Details from above:***

**Drug Allergies:** List Drug and reaction

## Your Past Surgeries: *Have YOU ever had any surgeries? If so, when? Please write approximate year or age.*

- ❑ Appendix
- ❑ Gallbladder
- ❑ Tonsillectomy
- ❑ Sinus
- ❑ Spleen Removed
- ❑ Colon/ Bowel

- ❑ Heart Bypass
- ❑ Blood Vessel (aorta, carotid-neck, legs)
- ❑ Knee: L R
- ❑ Hip: L R
- ❑ Disc: Neck Back

**Females:**
- ❑ Hysterectomy
- ❑ Ovaries Removed
- ❑ C-Section
- ❑ Tubal Ligation

**Males:**
- ❑ Prostate
- ❑ Vasectomy

***Other Surgery or comments:***

## Family History: Do any of your BLOOD RELATIVES have any of these conditions? State approximate age the condition developed.

These initials can be used: Father = F Mother = M Brother = B Sister = S Grandparents = GP Child = C

**Example: Diabetes: M(50), B(35), B(40), S(28) = (Mother, 2 brothers and 1 sister with diabetes; Mother diagnosed at age 50, etc.)**

- ❑ ADOPTED/ or No History Known
- ❑ Heart Bypass Surgery
- ❑ Angioplasty/Stents
- ❑ Heart attack
- ❑ Stroke
- ❑ Diabetes
- ❑ High Blood Pressure

- ❑ High Cholesterol
- ❑ Blood Clots
- ❑ Prolonged Bleeding
- ❑ Thyroid Disease
- ❑ Seizures
- ❑ Asthma
- ❑

- ❑ Depression
- ❑ Suicide
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Kidney Failure
- ❑ Liver Failure
- ❑

**Cancer/Type:**
- ❑ Colon
- ❑ Breast
- ❑ Prostate
- ❑ Lung
- ❑

## Social History

- ❑ **Smoking:** Current___ Past___ Cigs/day____ for____years Year Stopped_____
- ❑ **Smokeless Tobacco**
- ❑ **Drugs**

- ❑ **Alcohol:** Current____ Past____ **# per week**: beer____ wine____ liquor____ Year Stopped_____ In Recovery?_____

## Immunizations

Childhood imm. current/complete: Yes____ No____
Last **Tetanus** Shot_____
**Hepatitis A**: Yes___No___ **Hepatitis B**: Yes___No___
**Pneumococcal**: Yes___(year_____) No___