Generations Family Health NPs
Patient Name: _____ **DOB:** ____ / ____ / _____

Medical History:

Past Medical History: Have you ever had any of the following?

Allergies	☐ Yes	☐ No	Irregular Heart Rhythm	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No	Kidney Failure or Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bone Fracture as an Adult	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bronchiectasis	☐ Yes	☐ No	Obstructive Sleep Apnea	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer (**if yes, describe below**)	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Pulmonary Artery Hypertension	☐ Yes	☐ No
Coronary Artery Disease/Heart attack	☐ Yes	☐ No	Pulmonary Fibrosis(**if yes, describe below**)	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Recurrent Infections	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sarcoidosis	☐ Yes	☐ No
DVT or Pulmonary Embolism	☐ Yes	☐ No	Scleroderma	☐ Yes	☐ No
Esophageal Disease	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
GERD/Reflux	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Heart or Valve Defect	☐ Yes	☐ No	Sjogren's	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Skin Disorders (e.g., Psoriasis, Acne)	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Mycobacterial Infection	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No			

Please list all other medical conditions past and present:

_____

_____

_____

_____

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

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Allergies

Allergic to: ☐ IV Contrast Dye: Type_____

Please list medication or severe food allergies	Describe reaction

Height_____ **Weight_____**

Medications Taken Regularly

Include all oral, inhaled, intravenous, and subcutaneous medications as well as all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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Family History

Indicate if your family members have any of these diseases (GM=Grandmother, GF=Grandfather, Maternal=mother, Paternal=father's side)

Disease	Maternal			Paternal			Siblings			Children			
	Mom	GM	GF	Dad	GM	GF							
Asthma													
Autoimmune Disease Type:													
Cancer Type:													
COPD/ Emphysema													
Pulmonary fibrosis/ Interstitial Lung Disease													
Coronary artery disease/heart attack													
Diabetes Mellitus													
High cholesterol													
High blood pressure													
Frequent Pneumonia													
Pulmonary embolism (PE)													
Rheumatoid arthritis													
Stroke													
Osteoporosis/ Fragile Bones and/or Hip Fracture													
Other #1													
Other #2													

Other diseases that run in the family: _____

_____

_____

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Social History

1. Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed
2. Smoking History: ☐ I have **never** smoked
   I currently smoke: ☐ Cigarettes packs/day: _____ ☐ Cigar ☐ Pipe ☐ eCigarettes ☐ Other
   If you currently smoke, are you interested in quitting? ☐ Yes ☐ No
   I previously smoked: ☐ Cigarettes ☐ Cigar ☐ Other Age Started: _____ Age Stopped: _____
   Average packs/day: _____Are there smokers in home? ☐ Yes ☐ No
   Smokeless tobacco: ☐ Yes ☐ No Number of years: _____
3. Marijuana: ☐ Yes ☐ No Route: ☐ Inhaled ☐ Edible Medical: ☐ Yes ☐ No
4. Street/Illicit Drugs: ☐ Yes ☐ No If yes, which? _____
5. Alcohol Use: Any problems with alcohol now or in the past? ☐ Yes ☐ No
   Current number of drinks per week: _____ Type(s) of alcohol: _____
6. Exercise: Do you exercise regularly? ☐ Yes ☐ No
   Please Describe: _____
7. Fall Risk: Have you fallen in the past 3 months? ☐ Yes ☐ No
   Do you feel unsteady when standing? ☐ Yes ☐ No
   Do you use a cane, walker or wheelchair? ☐ Yes ☐ No
   Do you have a fear of falling? ☐ Yes ☐ No

Occupational History- Please start with the most recent job and work backwards

Job Title	Dates of Employment	Description	Health risks/exposures	Injuries/Illnesses

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Review of Symptoms: What symptoms have you experienced in the last **6 months**?

General
Weight change ☐ Yes ☐ No
Fatigue (impairs daily function) ☐ Yes ☐ No
Fever/Chills ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No
Decreased Appetite ☐ Yes ☐ No

Eyes
Visual changes ☐ Yes ☐ No
Dry, irritated or painful eyes ☐ Yes ☐ No

ENT/Mouth
Ear pain or drainage ☐ Yes ☐ No
Frequent sinus infections/ sinus pain ☐ Yes ☐ No
Hearing changes or loss ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No
Post Nasal Drip ☐ Yes ☐ No
Change in voice/ hoarseness ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No
Ulcers/Sores in the eyes, mouth or nose ☐ Yes ☐ No

Respiratory
Sputum Production ☐ Yes ☐ No
Chest tightness ☐ Yes ☐ No
Cough lasting >1 month ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Chest pain ☐ Yes ☐ No
Coughing up blood ☐ Yes ☐ No

Cardiovascular
Chest pain or heaviness ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Fainting or near fainting spells ☐ Yes ☐ No
Swelling of feet or legs ☐ Yes ☐ No
Shortness of breath lying flat in bed ☐ Yes ☐ No

Gastrointestinal
Abdominal pain ☐ Yes ☐ No
Blood in your stool ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Heartburn or indigestion ☐ Yes ☐ No
Vomiting or nausea lasting >1 day ☐ Yes ☐ No
Swallowing difficulty ☐ Yes ☐ No

Allergic/Immunologic
Watery or itchy eyes ☐ Yes ☐ No
Runny nose ☐ Yes ☐ No
Food intolerance ☐ Yes ☐ No

Psychological
Anxiety without clear explanation ☐ Yes ☐ No
Sadness lasting days or weeks ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Genitourinary
Blood in your urine ☐ Yes ☐ No
Urinating that is painful or difficult ☐ Yes ☐ No
Erection problems ☐ Yes ☐ No

Musculoskeletal
Joint pain or swelling ☐ Yes ☐ No
Muscle aches or tenderness ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No
Stiffness in the joints ☐ Yes ☐ No
Ulcers on the fingertips ☐ Yes ☐ No

Skin
Hives ☐ Yes ☐ No
Rash ☐ Yes ☐ No
Non-healing ulcers ☐ Yes ☐ No
Skin cancer ☐ Yes ☐ No
Color change or coldness in fingertips ☐ Yes ☐ No
Other changes in skin ☐ Yes ☐ No

Neurologic
Seizures ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Extremity pain or burning sensation ☐ Yes ☐ No
Numbness or tingling ☐ Yes ☐ No

Endocrine
Frequent urination ☐ Yes ☐ No
Increased thirst ☐ Yes ☐ No
Heat or cold intolerance ☐ Yes ☐ No
Menstrual changes ☐ Yes ☐ No

Hematological/Lymphatic
Inappropriate bleeding ☐ Yes ☐ No
Unexplained bruising ☐ Yes ☐ No
Swollen/Painful lymph nodes ☐ Yes ☐ No

Sleep
Snoring ☐ Yes ☐ No
Do you stop breathing at night? ☐ Yes ☐ No
Excessive Daytime Sleepiness ☐ Yes ☐ No
Falling asleep when you should not ☐ Yes ☐ No
Difficulty falling or staying asleep ☐ Yes ☐ No