Family Practice **Medical History Form**

Patient Name:_____SS#:_____Date:_____
Address:_____
Phone: (H)_____(W)_____(C)_____
Reason for today's visit:_____

Drug Allergies

_____
_____
_____
_____

Current medications

_____
_____
_____
_____
_____
_____

Family History

Disease	Mom	dad	Siblings	grandparent
Heart DZ	☐	☐	☐	☐
High BP	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/convulsions	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐

HOSPITALIZATIONS OR SURGERIES

Reason	Date	Reason	Date

Women only: Pregnant? ☐es ☐o Planning Pregnancy? ☐es ☐o
OB History: G_____P_____AB_____MC_____LMP_____

Medical History

__headache
__Shortness of breath
__Heart Palpitations
__Chest Pain
__Dizziness/fainting
__Peripheral vascular disease
__Allergies/Hay fever
__Asthma
__Bronchitis
__Pneumonia
__Ulcer
__GI Disorder
__Lactose intolerance
__Gallbladder disease
__Prostate Disease
__Incontinence
__Sexual/menstrual dysfunction
__Venereal disease
__Frequent Infections
__Hepatitis
__Anemia
__Arthritis
__Osteoporosis
__Nervousness
__Depression
__Gout
__Scarlet Disease
__Rheumatic fever
Vaccine History: __Mumps
__Measles
__Rubella
__Polio
__Diptheria
__Tetanus
__Shingles
other:_____

Habits

__smoke: Packs daily_____
How long_____
Interested in stopping?_____
__exercise routine_____
_____
__Coffee: cups daily:_____
other caffeine:_____
__Alcohol: type/amount:_____
__Diet: salt intake_____
fat intake_____
__sleep: ___ difficulty falling asleep
___continuity disturbance
___snoring
___early awakening
___daytime drowsiness
___contact with blood or bodily fluid at work?_____

REVIEW OF SYSTEMS

☐Neurologic_____ ☐GI_____ ☐Cardiovascular_____
☐GU_____ ☐Cerebrovascular_____ ☐Musculoskeletal_____
☐Peripheral vascular_____ ☐Dermatologic_____ ☐Hematologic_____

Reviewed BY_____