

Associates in Family Practice, P.C.

Health History

Name _____ Age _____ Birth Date _____ Today's Date _____

Currently Live Alone With Family **Marital Status** Married Divorced Never Married
 With Friends With Significant Other Separated Widowed

Check all items either Yes or No & give approximate date if past	NO	Yes Now	Yes Past	Date	Check all items either Yes or No & give approximate date if past	No	Yes Now	Yes Past	Date
Abnormal electrocardiogram (EKG)					Heart murmur as an adult				
Alcoholism					Hemorrhoids, rectal problems				
Anemia (Type)					Hepatitis (Type)				
Angina / chest pain					Hernia				
Arteriosclerosis					High blood pressure				
Arthritis					High cholesterol				
Asthma / Hay fever					HIV / AIDS				
Blood disease					Jaundice				
Broken bones					Kidney or bladder disease				
Cataracts					Kidney stones				
Chemical dependency					Low blood pressure				
Chemotherapy					Migraine headaches				
Chronic bronchitis / emphysema					Mitral valve prolapse				
Chronic liver disease					Night sweats				
Colon, bowel trouble-diverticulitis/colitis					Phlebitis				
Convulsions, seizures					Poor blood clotting				
Deafness or ringing ears					Psychiatric care				
Diabetes					Rheumatic fever				
Ear infections					Sexually transmitted/venereal disease				
Enlarged heart					Shortness of breath				
Epilepsy / seizures					Sinus trouble				
Forgetfulness					Skin disease / psoriasis / eczema				
Glaucoma					Stroke				
Gall stones					Thyroid problem				
Gout					Tuberculosis or positive T.B. test				
Head injury					Wakefulness, difficulty sleeping				
Heart attack					Weight loss or weight gain				

Habits _____ **Medications** _____

Do You	YES	NO	Daily Consumption
Smoke			Pkgs
Drink Coffee			Cups
Drink Alcohol			oz
Drink Beer			oz
Chew Tobacco			
Use Drugs			

Please list all medication you are now taking, including those you buy without a doctor's prescription.

Allergies
List anything that you are allergic to, such as medications, foods, etc, and indicate how each affects you.

Immunizations	Tetanus-date	Flu-date	German Measles-date	Pneumonia-date
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Hospitalizations (Not including normal pregnancies)		Serious Illness not requiring hospitalization	
Operation or Illness	Year	Illness	Year

Have you had?	Yes	No	When or since when?	Have you had pain or tightness in the chest which begins:	Yes	No	Yes	No	
Burning when urinating?				When exerting yourself?			When walking against a wind?		
Blood in urine?				After a heavy meal?			When walking up a hill?		
Loss of bladder control?				When upset or excited?			Radiates down the arm?		
Blood in the stool?				When walking fast?			Disappears if you rest?		
Alternating diarrhea/constipation?				Palpitations?			When walking in cold weather?		
Pain during/after bowel movement?				If you have chest pain or tightness Do you sleep on more than					
Black stools?				please explain			one pillow?		
Ribbon-like stools?				Do you wear artificial devices? (dentures, hearing aid)					
Require laxatives or enemas?				Yes	No	List			
Pain in calves of legs when walking?				Are You?					
Pain in the big toe?				Excessively cold			Excessively hot		
				Always hungry			Always thirsty		

Discharge from penis	one pillow?	Prostate trouble	Excessively cold	Excessively hot
Sexual difficulties			Always hungry	Always thirsty
WOMEN ONLY	Last Pap smear		Last Menstrual period	Methods of contraception
	Pregnancies #		Live births #	
Miscarriages or abortions #		Last Mammogram		Age periods started
Vaginal itching or burning	Vaginal discharge	Problems with menstrual periods	Other gynecological problems	Other breast disease
Sexual difficulties	Breast cancer	Discharge from nipple(s)	Problems during pregnancy	Ovarian cysts

Family History

Check condition(s) and relationship of any blood relative who has or has had any of the conditions listed.									Check condition(s) and relationship of any blood relative who has or had any of the conditions listed.								
	Yes	No	Father	Moth0-er	Broth0-er	Sister	Son	Daugh0-ter		Yes	No	Father	Moth0-er	Broth0-er	Sister	Son	Daugh0-ter
Alcoholism									High blood pressure								
Allergies									Kidney disease								
Anemia									Leukemia								
Arthritis									Liver disease								
Asthma / hay fever									Mental illness								
Birth defects									Migraines								
Cancer									Nervous breakdown								
Colon / bowel trouble									Obesity								
Congenital heart defects									Rheumatic fever								
Diabetes									Sickle-cell anemia								

Emphysema										Stomach ulcer									
Epilepsy										Stroke									

I certify that the above information is correct to the best of my knowledge. I will not hold Associates in Family Practice, P.C. or members of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date