

Associates in Family Practice, P.C.

Health History

Name _____ Age _____ Birthdate _____ Today's Date _____

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

Do You Yes No Daily Consumption
 Smoke _____ Pkgs
 Drink Coffee . . _____ Cups
 Drink Alcohol . . _____ oz.
 Drink Beer . . . _____ oz
 Chew Tobacco _____
 Use Drugs
 Type _____
 Frequency _____

Medications

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 _____

Hospitalizations (Not including normal pregnancies)

Operation or Illness _____ Year _____

Serious Illness not requiring hospitalization

Illness _____ Year _____

Have you had? Yes No When or since when?

Burning when urinating? _____
 Blood in urine? _____
 Loss of bladder control? _____
 Blood in the stool? _____
 Alternating diarrhea/constipation? _____
 Pain during/after bowel movement? _____
 Black stools? _____
 Ribbon-like stools? _____
 Require laxatives or enemas? _____
 Pain in calves of legs when walking? _____
 Pain in the big toe? _____

Have you had pain or tightness in the chest which begins:

Yes No Yes No
 When exerting yourself? When walking against a wind?
 After a heavy meal? When walking up a hill?
 When upset or excited? Radiates down the arm?
 When walking fast? Disappears if you rest?
 Palpitations? When walking in cold weather?
 If you have chest pain or tightness Do you sleep on more than
 please explain: _____ one pillow?

MEN ONLY Discharge from penis Pain in testicles
 Sexual difficulties Prostate trouble

Do you wear artificial devices? (dentures, hearing aid)

Yes No List _____

Are You?

Excessively cold Excessively hot 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.	Yes	No	Father	Mother	Brother	Sister	Son	Daughter	Check condition(s) and relationship of any blood relative who has or has had any of the conditions listed.	Yes	No	Father	Mother	Brother	Sister	Son	Daughter	
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 _____