The Family Doctor, LLC
PATIENT HISTORY

Name:_____ Date of Birth:_____

Previous Physician:_____ Location:_____

What type of complaint or disease is the reason for this visit?_____

SOCIAL HISTORY

Home situation

□ Single □ Married □ Divorced □ Widowed □ Domestic Partnership □ Children_____ Are they healthy?_____

Employment

□ Full-time □ Part-time □ Retired □ Disabled □ Homemaker

Occupation (type of work/job):_____

Habits: Do you smoke? □ No □ Yes If Yes, how many packs a day?_____Year started: _____ Year quit:_____

Do you drink alcohol? □ No □ Yes Year quit:_____

In the past year, have you ever had 8 or more drinks on one occasion or had 14 drinks (7 for woman) in one week? □ No □ Yes

Have you ever had problems with drug use?_____

Religious preference_____ Church if any?_____

PAST MEDICAL HISTORY

Please list other diseases from which you currently suffer from (heart, lung, etc.):_____

_____

_____

Please list other medical conditions from which you have suffered in the past:_____

_____

_____

Please list any surgeries/procedures/operations you have had, reason for surgery, and date of surgery:_____

_____

_____

MEDICATIONS

Prescription medications	*Dose*	*How often taken*

Over-the-counter medications	*Dose*	*How often taken*

Herbal preparations	*Dose*	*How often taken*

ALLERGIES OR ADVERSE DRUG REACTIONS (Please list drug and type of reaction):_____

_____

_____

FAMILY HISTORY

Place an 'X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited disorder)								

Mother □ Alive □ Deceased Age:_____ Medical conditions:_____

Father □ Alive □ Deceased Age:_____ Medical conditions:_____

SYSTEMS REVIEW Are you currently having any of the following symptoms?

Gastrointestinal
□ Poor appetite
□ Abdominal pain
□ Indigestion
□ Trouble swallowing
□ Diarrhea
□ Constipation
□ Change in bowel habits
□ Nausea or vomiting
□ Rectal bleeding or blood in stools
□ History of liver disease or abnormal liver tests

General
□ Weight gain/loss of 10+ lbs during last 6 months
□ Poor sleep
□ Fever
□ Headache
□ Depression

Cardiovascular
□ Chest pain
□ History of angina or heart attack
□ History of high blood pressure
□ History of irregular heart beat
□ History of poor circulation

Eyes, Ears, Nose, Throat
□ Blurred vision
□ Other change in vision
□ History of glaucoma or cataract
□ Loss of hearing
□ Ringing in ears
□ Sinus problems
□ Hoarseness

Pulmonary/Lungs
□ Shortness of breath
□ Persistent cough
□ Coughing up blood
□ Asthma or wheezing

Genitourinary
□ Frequent or painful urination
□ Blood in urine
□ Urinary incontinence

Muscle/Joint/Bone
□ Swelling of ankles or legs
Pain, weakness or numbness in
□ Arms or hands
□ Back or hips
□ Legs or feet
□ Neck or shoulders

Skin
□ Itching
□ Easy bruising
□ Change in moles

Neurologic
□ History of stroke
□ Blackouts or loss of consciousness

Endocrine
□ History of diabetes
□ History of thyroid disease
□ Change in tolerance to hot or cold weather
□ Excessive thirst

Women only
□ Abnormal Pap Smear
□ Bleeding between periods
Date of last Mammogram:_____

Men only
PSA Level_____ When?_____ Results?_____

Anything else?
□ Are you experiencing an unusually stressful situation?
□ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: If Yes, give approximate year given
Pneumoccal □ No □ Yes Year_____ Hepatitis- A □ No □ Yes Year_____
Hepatitis- B □ No □ Yes Year_____ Tetanus □ No □ Yes Year_____

Advance Directive □ No □ Yes In an emergency, do you want CPR_____ Ventilator?_____Tube feeds?_____
Living Will □ No □ Yes
Please bring a copy for our records