PAST FAMILY, MEDICAL, & SOCIAL HISTORY (two pages)

NAME _____ DOB _____

ALLERGIES ☐ None (please list allergies **and what happens to you when you take it**)
Drug Allergies: _____
_____
Food Allergies:_____

CURRENT MEDICATIONS ☐ None
_____ _____
_____ _____
_____ _____
(Continue on back if needed.)

OTHER MEDICAL PROVIDERS: (Please list all of your healthcare providers)
Specialists: _____
Others: _____

ADVANCED DIRECTIVES: Do you have any of the following? Can we have a copy if not already given?
☐ Health Care Proxy/POA ☐ Living Will ☐ Power of Attorney ☐ DNR

MEDICAL HISTORY: (please check all that apply)

☐ Allergies - seasonal
☐ Allergies – perennial
☐ Anemia
☐ Asthma
☐ Blood Clots
☐ Cancer, _____
☐ Diabetes, Type I or II
☐ Enlarged Prostate
☐ Fibromyalgia
☐ Gall Stones
☐ GERD/ Reflux
☐ Headaches, migraine/tension
☐ Heart Failure
☐ Heart Disease
☐ Heart Attack
☐ Hemophilia, A or B
☐ High Cholesterol
☐ High Blood Pressure
☐ History of Fracture _____
☐ Irregular Heart Rhythm
☐ Kidney Stones
☐ Lung Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Psychological Illnesses
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease
☐ UTI, recurring
☐ Other: _____
_____
_____

SURGICAL HISTORY: (Please indicate date & details if possible)

☐ Appendectomy
☐ Arthroscopy: _____
☐ Back Surgery
☐ Biopsy: _____
☐ Cataract Removal
☐ Colon Surgery
☐ D&C
☐ Fracture Repair, _____
☐ Gall Bladder Removal
☐ Heart Surgery, _____
☐ Hernia Repair
☐ Hysterectomy and ovaries
☐ Hysterectomy without ovary removal
☐ Joint Replacement, _____
☐ Mastectomy/Lumpectomy
☐ Mole Removal _____
☐ Orthopedic Surgery: _____
☐ Prostatectomy
☐ Stents (where): _____
☐ Tonsil/Adenoidectomy
☐ Tubal Ligation
☐ Tubes in Ears
☐ Urinary Surgery, _____
☐ Vasectomy
☐ Other: _____
_____
_____

SUBSTANCE ABUSE HISTORY: ☐ None Other: _____

MENTAL HEALTH HISTORY: ☐ None Other: _____

COMMUNICABLE DISEASE HISTORY: ☐ None Other: _____

FAMILY HISTORY: Indicate which family member with an **x** in the column

Mat GM/GF = maternal grandmother/grandfather Pat GM/GF = paternal grandmother/grandfather

	Mother	Father	Brother	Sister	Son	Daughter	Mat GM	Mat GF	Pat GM	Pat GF	Mat Uncle	Mat Aunt	Pat Uncle	Pat Aunt
Alcoholism/Drug Abuse														
Alzheimer's Disease:														
Asthma/Bronchitis/Emphysema														
Bleeding Tendency:														
Cancer, _____														
Diabetes, Type I or II:														
Enlarged Prostate:														
Gall Stones:														
Heart Disease:														
High Blood Pressure:														
High Cholesterol:														
Kidney Disease:_____														
Obesity:														
Osteoarthritis:														
Osteoporosis:														
Psychiatric Illness														
Rheumatoid Arthritis:														
Seizure Disorder:														
Stroke:														
Thyroid Disease:														
Other:_____														

TOBACCO/ALCOHOL/SUPPLEMENTS: ☐Tobacco use presently? ☐ Previous use? ☐ Never smoked.
If present or previous use: ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco
How many/day? _____ How long have you/did you used tobacco? _____ Quit when? _____

Do you use **Alcohol**? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _____ How often? _____

Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _____ How often? _____

Vitamin or Diet Supplements: Type: _____ How often? _____

SOCIAL HISTORY:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children: _____
Who lives in your household with you? _____

JOB/EMPLOYMENT – if retired, please answer with what you did before retirement
Presently employed? Yes _____ No _____
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled

Where do/did you work: _____

What is/was your job: _____

Religion: (any needs or concerns affecting your healthcare) _____

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS: _____

_____

Date: _____ Signature: _____