FAMILY CARE PLUS

PATIENT'S MEDICAL HISTORY FORM

Patient's Name _____ Today's Date ___/___/_____

Age _____ Birth date ___/___/_____ Date of last physical examination ___/___/_____

Past Medical History

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical
- ❑ Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

Men only

- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other _____

Women only

- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other _____

Date of last menstrual period:
___/___/_____

Date of last Pap Smear:
___/___/_____

Date you had last mammogram:
___/___/_____

Are you pregnant? ❑Yes ❑No
Number of children ___
Number of pregnancies ___

Children Only

Date of last well child exam:
___/___/_____

Date of last vision screening:
___/___/_____

Date of last hearing screening:
___/___/_____

Up-to-date immunization:
❑Yes ❑No

Social History

- ❑ Alcohol
- ❑ Caffeine
- ❑ Tobacco
- ❑ Street Drugs _____
- ❑ Other _____

Occupational

Check if your work exposes you to:
- ❑ Stress
- ❑ Heavy Lifting
- ❑ Hazardous Substances
- ❑ Other _____

Occupation _____

Past Surgical History

1. Surgery: _____
   Year: _____
2. Surgery: _____
   Year: _____
3. Surgery: _____
   Year: _____
4. Surgery: _____
   Year: _____
5. Surgery: _____
   Year: _____
6. Surgery: _____
   Year: _____

FAMILY CARE PLUS
PATIENT'S MEDICAL HISTORY FORM

Family History				
Check the box next to family member with the listed diseases				
Arthritis, Gout	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
High Blood Pressure	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
Cancer	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
Chemical Dependency _____	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
Diabetes	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
Heart Disease, Strokes	❑ Father	❑ Mother	❑ Brothers	❑ Sisters
Other _____	❑ Father	❑ Mother	❑ Brothers	❑ Sisters

Medications currently taking	Allergies to any medication
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____

Pharmacy Information	
Name:	Phone Number: ( ) _____-_____

To the best of my Knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____	___/___/_____	_____	_____
Signature of Patient, Parent, Guardian	Date	Printed Name	Relationship to Patient