HILLIARD FAMILY MEDICINE PATIENT HISTORY SHEET

Name: Today's Date:

Marital Status: S M D W Gender: M F Age: Date Of Birth:

Education: Years High School; Years College; Years Post Graduate Occupation:

Name And Address Of Your Previous Physician:

Current Concerns:

DRUG ALLERGIES & TYPE OF REACTION

CURRENT PRESCRIPTION AND OTC MEDICATIONS

FAMILY HISTORY

Checkmark Family Members With These Conditions:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Other
Heart Disease							
High Blood Pressure							
Migraine Headaches							
Stroke							
Glaucoma							
Diabetes							
Epilepsy/Seizures							
High Cholesterol							
Bleeding Disorder							
Kidney/Liver Disease							
Asthma							
Thyroid Disease							
Cancer (what types)							
Drugs/Alcoholism							
Mental Illnesses							

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

PAST MEDICAL HISTORY (SPECIFY DIAGNOSIS FOR EACH PROBLEM IF KNOWN)

☐ Headache	☐ Gall Bladder Disease	☐ Chronic Rashes
☐ Shortness of Breath	☐ Prostate Disease	☐ Rheumatic Fever
☐ Heart Attack or Angina	☐ Rectal Bleeding	☐ Kidney Stones
☐ Heart Murmur	☐ Menstrual Dysfunction	☐ Seizures or Convulsions
☐ Chest Pain	☐ Sexually Transmitted Disease	☐ High Cholesterol
☐ Fainting	☐ Frequent Infections	☐ HIV/AIDS
☐ Peripheral Vascular Disease	☐ Hepatitis	☐ Diabetes
☐ Allergies or Hay Fever	☐ Anemia	☐ Glaucoma
☐ Asthma	☐ Arthritis	☐ Alcoholism
☐ Chronic Bronchitis or Emphysema	☐ Nervousness or Anxiety	☐ Drug Dependency
☐ Pneumonia	☐ Depression	☐ Cancer or Tumor (Type?)
☐ Goiter or Thyroid Problems	☐ Gout	☐ Other (specify)
☐ Ulcer/GI Disorder	☐ High Blood Pressure	☐ Other (specify)

HABITS AND SOCIAL HISTORY

☐ Tobacco: Type & Amount Used?	If Quit, When?
☐ Alcohol: Type & Amount Used?	Frequency Of Drinking?
☐ Drugs: Type & Amount Used?	Frequency Of Use?
☐ Caffeine: Type & Amount Used?	Frequency Of Use?
☐ Exercise: Type & Frequency?	****Date Of Last Tetanus Booster?**

FOR WOMEN ONLY

Pregnant Now? ☐ Y ☐ N	Date Of Last Pap Smear?	Any Prior Abnormal Pap?
Planning Pregnancy? ☐ Y ☐ N	Number Of Times Pregnant?	Number Of Deliveries?
Current Method Of Birth Control? ☐ None ☐ Other (specify):		Date Of Last Period?
Age At First Period?	Age At Menopause?	If Menopausal, Have You Had A Bone Density Test?
Name And Address Of Your OB/GYN, If You Have One?		