Family Medicine, P.C.

Welcome to our practice! We appreciate your trust in us and look forward to working with you to maintain your health and develop healthy habits. Please fill out the following pages to the best of your ability. After you have completed the questionnaire, please bring it to one of the administrative assistants at the front desk.

Name _____
(Last) (First) (MI)

Preferred Name (if any) _____ **Date of Birth**_____

Age _____ **Social Security Number (at least last four digits)** _____**Sex** _____

Spouse _____
(Last) (First) (MI)

Parents or Legal Guardian (if applicable) _____

How did you hear about Family Medicine, P.C.? _____

Ethnicity(check one box) ☐ Non-Hispanic ☐ Hispanic or Latino

Race
☐ White
☐ Black or African American
☐ Asian
☐ Hawaiian/Pacific Islander
☐ Native American/Alaska Native

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Partner

Mailing Address_____
(Street) (City) (State) (Zip)

Email Address_____

Are you currently….
☐ Employed ☐ Self-employed What is or was your occupation? _____
☐ Unemployed ☐ Retired

What pharmacy do you prefer to use? _____
(please include address or cross streets)

In Case of Emergency

Person to Be Notified _____Relationship _____

Cell/Home Phone _____

HEALTH HISTORY Name _____ Date of Birth _____

What brings you in our office today?

_____

Please check any of the following medical problems that you have had:

- □ Abnormal weight loss
- □ Abnormal weight gain
- □ Excessive fatigue
- □ Insomnia
- □ Anemia
- □ Cancer or tumor

- □ Glasses or contacts
- □ Glaucoma
- □ Cataracts
- □ Other problems with vision

- □ Hearing loss
- □ Ear problems
- □ Ringing in ears

- □ Allergies
- □ Frequent sinus infections

- □ Dentures
- □ Dental problems
- □ Recurrent sores in mouth

- □ Angina
- □ Frequent chest pain
- □ Irregular heartbeat
- □ Heart murmur

- □ Rheumatic fever

- □ High cholesterol
- □ Heart failure
- □ Heart attack
- □ High blood pressure

- □ Breathing problems
- □ Frequent bronchitis
- □ Emphysema
- □ Pneumonia
- □ Asthma

- □ Heartburn
- □ Ulcer disease
- □ Gallbladder disease
- □ Blood in stool
- □ Hepatitis
- □ Diarrhea, constipation, or other changes in bowel habits
- □ Hemorrhoids
- □ Abdominal pain
- □ Colon polyp

- □ Urinary frequency
- □ Bladder infections
- □ Prostate problems
- □ Urinary incontinence
- □ Kidney problems

- □ Arthritis or joint pain

- □ Gout
- □ Broken bones

- □ Rashes
- □ Hives
- □ Moles

- □ Seizure
- □ TIA
- □ Stroke
- □ Numbness
- □ Weakness
- □ Memory loss
- □ Headaches

- □ Depression
- □ Anxiety/panic attacks
- □ Suicide attempt
- □ Physical abuse
- □ Sexual abuse
- □ Mental illness

- □ Diabetes
- □ Thyroid disease

- □ Sexually transmitted disease
- □ Abnormal PAP smear
- □ Abnormal mammogram
- □ Breast lump

Have you been exposed to or do you have a close family member with?

- □ HIV/AIDS
- □ Hepatitis
- □ TB

Other medical problems not listed above:

1. _____
2. _____
3. _____

Name _____**Date of Birth** _____

List all surgeries you have had and when:

1. _____
2. _____
3. _____
4. _____

List all health care providers you have seen in the past or currently seeing:

1. _____ _____
2. _____
3. _____
4. _____

Pregnancies

# of pregnancies _____ Live births _____

Miscarriages _____ Abortions _____

Have you ever had a blood transfusion? Yes ____ No ___

If YES, what year? _____ Why? _____

_____

Please list *the last year* **in which you have had any of the following:**

Physical exam _____ PAP Smear _____

_

Mammogram _____ Testicular exam_____

Colonoscopy _____ Stool Cards (IFOB) _____

Prostate exam _____ Bone density _____

Cholesterol test _____ Dental exam _____

Eye exam _____

Vaccines

Please list *the last year* **you had any of the following vaccines:**

Tetanus _____ Flu _____
Pneumonia_____ MMR _____
Hepatitis B series _____ PPD(TB)_____
Hepatitis A series _____

COVID-19 vaccination? Yes _____ No _____

Moderna _____ Pfizer _____ J&J _____

Did you complete the series? _____

Did you receive a booster? Yes _____ No _____

Did you have any complications? _____

_____

_____

Please describe your use of tobacco products:

- □ Never smoked or used any tobacco products
- □ Former smoker or tobacco user
- □ Cigarettes
- □ E-cigarettes
- □ Smokeless tobacco
- □ Pipe
- □ Cigars

How much do you or did you smoke per day? _____

For how many years? _____

Do you wish to quit?

- □ Now
- □ Soon
- □ Eventually
- □ Never

Have you quit? _____ When? _____

How much alcohol do you drink on an average week?

_____

Do you have a problem with alcohol? _____

Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc.)?

_____

Do you have a medical marijuana card? Yes _____ No_____

How much caffeine do you drink daily (coffee, tea, colas)?

_____

Are you sexually active? Yes _____ No _____

Is (or are) your partner(s) Male _____ Female_____

_____ Both male and female _____

Do you use contraception? Yes _____ No _____

- □ Condoms IUD _____
- □ Pill

Please check which of the following behaviors you follow:

- ❑ Wear seatbelts
- ❑ Fire extinguisher in house
- ❑ Living Will or Advanced Directive
- ❑ Exercise? How often? _____
  Type of exercise? _____
- ❑ Wear helmet while riding bike or motorcycle
- ❑ Perform self-breast exams regularly
- ❑ Perform self-testicular exam
- ❑ Smoke detectors in house
- ❑ Gun(s) in house
  Gun(s) secured by lock(s)? _____

Please list ALL medications you are taking including over-the-counter medications and vitamins.

Name of Medication	Dose or Strength	How often do you take it?	How long have you been taking it?	Why do you take it?

Do you have any drug allergies? YES _____ or NO_____ Please list below and include reaction

Medication	Reaction

Family History

Are you adopted? ☐ No ➡ Complete the following information about your **blood** relatives.

☐ Yes ➡ If known, complete the following information about your **blood** relatives (include children). Exclude adoptive parents, siblings and adopted children.

Father ☐ Alive (Age___) ☐ Deceased (Age____) ☐ unknown **Cause of Death:** _____ ☐ unknown

Mother ☐ Alive (Age___) ☐ Deceased (Age___) ☐ unknown **Cause of Death:** _____ ☐ unknown

	Number Alive	*Approximate Age(s)*	*Number Deceased*	*Approximate Age(s)at Death*	*Cause(s)of Death*		
Brothers	_____	_____	_____	_____	_____		unknown
Sisters	_____	_____	_____	_____	_____		• unknown
Sons	_____	_____	_____	_____	_____		unknown
Daughters	_____	_____	_____	_____	_____		unknown

Place a check mark (✓) in the appropriate boxes to identify all illnesses/conditions **which you know have occurred** in your **blood relatives**. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness or condition.

Illness/Condition	Family Members								Describe
	Grandparents	Father	Mother	Brothers	Sisters	Sons	Daughters	None	
Cancer (Describe the type for each person)									
Heart Disease									
Diabetes									
Stroke/TIA									
High Blood Pressure									
High Cholesterol or Triglycerides									
Liver Disease									
Alcohol or Drug Abuse									
Anxiety, Depression or Psychiatric Illness									
Tuberculosis									
Genetic Disorder									
Kidney Disease									
Other-describe									
Other-describe									
Other-describe									

Other information about your family which you want us to know _____

_____

_____

_____

My Medical History Disclosure Statement

I, _____ certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date_____

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