FAMILY, MEDICAL & SOCIAL HISTORY

NAME ____ DOB ______________________

ALLERGIES ☐ None (please list allergies **and what happens to you when you take it**)

Drug Allergies: ____

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Food Allergies: ____

PHARMACY: Local: ________________________ **Mail away**:___________________________________

CURRENT MEDICATIONS (include over the counter and vitamins/supplements) ☐ None

____ ____

____ ____

____ ____

(Continue on back if needed.)

MEDICAL HISTORY: (please check all that apply) **enter date and/or details on blank line**

- ☐ Abdominal Aortic Aneurysm
- ☐ Addiction to: ___________________________
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Allergies (environment) __________________
- ☐ Arthritis (type)___________________________
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma (type)____________________________
- ☐ Atrial fibrillation
- ☐ ADHD/ADD
- ☐ Bipolar Disorder
- ☐ Blood Clots (where) ____________________
- ☐ Bleeding Disorder ______________________
- ☐ Cancer (where)__________________________
- ☐ Carotid Stenosis
- ☐ Cataracts
- ☐ COPD
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Dermatitis
- ☐ Diabetes, Type I or II ___________________
- ☐ Emphysema
- ☐ Enlarged Prostate
- ☐ Epilepsy
- ☐ Erectile Dysfunction (ED)
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ GERD/ reflux/ heartburn
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV infection
- ☐ Hearing loss
- ☐ Headaches, migraine/tension
- ☐ Heart Failure
- ☐ Heart Disease _________________________
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemochromatosis
- ☐ Hemophilia, A or B ____________________
- ☐ Hepatitis (type)________________________
- ☐ Hernia (where)________________________
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ History broken bone ___________________
- ☐ Hypothyroid
- ☐ Irregular Heart Rhythm
- ☐ Kidney Disease _______________________
- ☐ Lung Disease _________________________
- ☐ Lupus
- ☐ MS Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Psoriasis
- ☐ Seizure disorder
- ☐ Sickle Cell Anemia
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Testosterone deficiency
- ☐ Thyroid Disease _____________________
- ☐ TIA
- ☐ Tuberculosis (TB)
- ☐ Ulcer (Where) ______________________
- ☐ UTI, recurring
- ☐ Other: ______________________________

SURGICAL HISTORY: (Please indicate **date & details**)

- ☐ Appendectomy
- ☐ Arthroscopy (where)___________________
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Carpal Tunnel Release
- ☐ Cataract Removal
- ☐ Circumcision
- ☐ Colon Surgery ________________________
- ☐ Colposcopy
- ☐ D&C
- ☐ Fracture Repair, _______________________
- ☐ Gastric bypass/banding _________________
- ☐ Gall Bladder Removal
- ☐ Heart Surgery, ________________________
- ☐ Hernia Repair (where)__________________
- ☐ Hysterectomy and ovaries
- ☐ Hysterectomy without ovary removal
- ☐ Joint Replacement, _____________________
- ☐ LEEP procedure
- ☐ Lasik
- ☐ Mastectomy/Lumpectomy ______________
- ☐ Mole Removal _______________________
- ☐ Nephrectomy (kidney removal) __________
- ☐ Orthopedic Surgery: ___________________
- ☐ Ostomy _____________________________
- ☐ Pacemaker
- ☐ Prostate Removal
- ☐ Splenectomy
- ☐ Stents (where): _______________________
- ☐ Testicular surgery
- ☐ Thyroidectomy
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal ligation
- ☐ Urinary Surgery, _____________________
- ☐ Vasectomy
- ☐ Other: _____________________________

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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, ***Note type under each relative**														
Diabetes, Type I or II:														
Heart Disease:														
High Blood Pressure:														
High Cholesterol:														
Kidney Disease:__________														
Liver Disease: ___________														
Obesity:														
Osteoarthritis:														
Osteoporosis:														
Psychiatric Illness														
Rheumatoid Arthritis:														
Seizure Disorder:														
Stroke:														
Thyroid Disease:														
Other:_________________														

Comment lines for any above that need explanation: ____

____

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

TOBACCO/ALCOHOL/SUPPLEMENTS:
☐ Never smoked. ☐ Smoke now ☐ Cigarettes ______ packs/day. Started (when) _____________
☐ Quit (when): _______ How long did you smoke: ________ How much: ___________

☐ Cigars (how many): _________/day or week ☐ Smokeless tobacco (How much): ______________
☐ Vape (How much) _____________________

Do you drink **Alcohol**? ☐ No ☐ Yes What do you drink? ____________ How often? __________________

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

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

What is the highest level of school that you have finished?
☐ Less than high school degree ☐ High school diploma or GED ☐ Some College ☐ College Degree

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 health care) ________________________________

In the past year, have you or any family member you live with been unable to get any of the following when it was really needed:
☐ Food ☐ Utilities
☐ Clothing ☐ Medicine or other health care

Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
☐ Yes ☐ No

Do you feel physically and emotionally safe where you currently live?
☐ Yes ☐ No

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS: ______________________________________

____

Date: __________________ Signature: ____