

South Point Family Practice Patient History Sheet

Name: _____ DOB: ___/___/_____ Sex: M / F (circle)

Past Medical History: Have you ever had any of the following? (Circle)

Anemia	Diabetes	Migraines
Angina	Emphysema	Phlebitis
Anxiety	Enlarged Heart	Pneumonia
Arthritis	Gallstones	Rheumatic Fever
Asthma	Glaucoma	Sexual Diseases
Blood Transfusion	Heart Attack	Sickle Cell Anemia
Cancer	Hepatitis	Stomach Ulcers
Cataracts	High Blood Pressure	Stroke
Chronic Intestinal Disease	Insomnia	Thyroid Disease
Depression	Kidney Disease/Stone	Tuberculosis

Allergies: Please list any allergies you have medications, foods or pollens, etc.

Medications: Please list all current medications.

Surgical History: (Give date or age)

Appendix _____	Hemorrhoids _____	Ovaries Removed _____
Vasectomy _____	Hernia _____	Prostate _____
Breast _____	Hysterectomy _____	Stomach _____
Gall Bladder _____	Colon _____	Tonsils _____
Heart _____	Kidney _____	Tubal Ligation _____

Other: _____

Hospitalization

Date or Age _____	Reason _____
Date or Age _____	Reason _____
Date or Age _____	Reason _____
Date or Age _____	Reason _____
Date or Age _____	Reason _____

Name: _____

DOB: ____/____/____

Family History

Number of siblings _____ Healthy? _____ Number of children _____ Healthy? _____

<u>Family Member</u>	<u>Alive/Deceased</u> <i>(Please circle)</i>	<u>Age</u>	<u>Chronic Medical Problems?</u> <i>(Please List)</i>
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Father Alive/Deceased _____

Mother Alive/Deceased _____

Brother #1 Alive/Deceased _____

Brother #2 Alive/Deceased _____

Brother #3 Alive/Deceased _____

Sister #1 Alive/Deceased _____

Sister #2 Alive/Deceased _____

Sister #3 Alive/Deceased _____

Paternal Grandfather Alive/Deceased _____

Paternal Grandmother Alive/Deceased _____

Maternal Grandfather Alive/Deceased _____

Maternal Grandmother Alive/Deceased _____

Social History

Do you smoke? Yes / No If so, how much? _____

Alcohol Use None / Social

Marital Status Single / Married / Divorced / Widowed

Occupation _____

Education Middle School / High School / College / Post Graduate

Exercise Regular / Not Regular

Seat Belt Use Yes / No

Drug Use Yes / No

Sexual Activity Yes / No

Travel Yes / No

Pets at Home? Yes / No

Occupational Exposure _____

Last eye exam _____

Last dental exam _____

Last tetanus booster _____

Women only:

Last mammogram _____

Last Pap smear _____