

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)

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

HABITS AND SOCIAL HISTORY

<input type="checkbox"/> Tobacco: Type & Amount Used?	If Quit, When?
<input type="checkbox"/> Alcohol: Type & Amount Used?	Frequency Of Drinking?
<input type="checkbox"/> Drugs: Type & Amount Used?	Frequency Of Use?
<input type="checkbox"/> Caffeine: Type & Amount Used?	Frequency Of Use?
<input type="checkbox"/> Exercise: Type & Frequency?	**Date Of Last Tetanus Booster?

FOR WOMEN ONLY

Pregnant Now? <input type="checkbox"/> Y <input type="checkbox"/> N	Date Of Last Pap Smear?	Any Prior Abnormal Pap?
Planning Pregnancy? <input type="checkbox"/> Y <input type="checkbox"/> N	Number Of Times Pregnant?	Number Of Deliveries?
Current Method Of Birth Control? <input type="checkbox"/> None <input type="checkbox"/> 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?		