the Family Health Center

Patient Name: _____ Date of Birth:_____

TODAYS DATE: _____

PATIENT HEALTH HISTORY: ADULT

Your answers on this form will help your healthcare team obtain an accurate history of your medical concerns and conditions. Please do your best to complete all four pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Personal Medical History: Please indicate with an **X** if you have had the following:

Condition:	X	Condition:	X	Condition:	X
CARDIOVASCULAR		**BLOOD CONDITION**		**CANCER**	
Atrial Fibrillation		Anemia		Blood/ Leukemia	
Congestive Heart Failure		Blood Transfusion		Brain	
Heart Attack		Blood Clot		Breast	
High Cholesterol				Colon	
Hypertension		**EMOTIONAL/BEHAVIORAL**		Lung	
		Alcoholism		Ovarian	
EYES/EARS		Alzheimer's Disease		Prostate	
Blindness		Anxiety		Other:	
Cataract		Attention Deficit Disorder			
Glaucoma		Bipolar Disorder		**ENDOCRINOLOGY/RENAL**	
Hay Fever		Depression		Chronic Renal Failure	
Hearing Loss		Drug Use		Diabetes Type 1	
		Eating Disorder		Diabetes Type 2	
GASTROINTESTINAL		Memory Problems		Dialysis	
Celiac Disease		Post-Traumatic Stress Disorder		Kidney Disease/Kidney Stone	
Colitis		Schizophrenia		Thyroid Disorder	
Colon Polyps				Urinary Tract Infection-frequent	
Crohn's Disease (Granulomatous)		**MUSCULOSKELETAL**			
Diverticulitis		Arthritis		**NEUROLOGICAL**	
Gastrointestinal Bleeding		Back/Neck Injury		Migraine/Headaches	
GERD (heart burn/reflux)		Carpal Tunnel Syndrome		Seizure Disorder	
Hemorrhoid		Chronic Pain		Stroke	
Hepatitis		Gout		Tremor	
Irritable Bowel Syndrome		Osteoporosis			
Liver Disease				**OTHERS**	
Pancreatitis		**RESPIRATORY**		Autoimmune Disorder	
		Asthma		Erectile Dysfunction	
PREGNANCY		COPD (Emphysema)		Fibromyalgia	
Number of pregnancies:		Pneumonia		HIV	
Number of live births:		Pulmonary Embolism		Skin Condition	
		Respiratory Disorder			
		Sleep Apnea			
		Tuberculosis			

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Please List Your Preferred Pharmacy:_____ **Location:**_____

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

ALLERGIES:

Source: (medications, pollens, food, animals, other)	Type of Reaction

SURGICAL HISTORY: Please indicate with an **X** in the appropriate box if the following procedure is applicable to you.

Surgical Procedure	X	Year	Surgical Procedure:	X	Year
Abdominal Surgery			Heart surgery		
Appendectomy (Appendix)			Hernia Repair		
Back Surgery			Hip Surgery		
Biopsy			Hysterectomy		
Breast Biopsy			Knee Surgery		
Breast Surgery			LEEP (Cervix Surgery)		
Colonoscopy			Ovary Removal		
Coronary Bypass			Sigmoidoscopy		
Coronary Stent			Sinus Surgery		
Cosmetic Surgery			Tonsillectomy		
EGD (Stomach Endoscopy)			Tubal Ligation		
Cataract			Other:		
Gallbladder Removal			Other:		

FAMILY HISTORY: Please indicate with an **X** if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Cancer				
Diabetes				
Glaucoma				
Heart Disease				
High Blood Pressure				
Mental Illness				
Stroke				

LIFESTYLE / SOCIAL HISTORY

Do you smoke tobacco (*circle one*)? **YES or NO**

If yes, about how many/day? _____

Have you smoked in the past? YES or NO *Years smoked _____ *Average Packs per Day _____

Do you drink alcohol (*circle one*)? **YES or NO**

If yes, please answer the following questions:

Approximately, how many drinks per week? 0-3 3 or more

If 3 or more drinks per week, how many per day? 0-2 2-5 5 or more

What is your favored drink type? Beer Wine Liquor Other: _____

Have you ever felt you should cut down on your drinking? YES or NO
Have people annoyed you by criticizing your drinking? YES or NO
Have you ever felt bad or guilty about your drinking? YES or NO
Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover? YES or NO

Do you use other substances such as marijuana or other drugs (*circle one*)? **YES or NO**

If yes, about how many times? Per week _____ Per day _____

Please list substance(s) used: _____

How many days in the last two weeks have you been bothered by the below symptoms?

Little Interest, Pleasure in Activities	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Feeling Down, Depressed, Hopeless	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All

Please continue on to the following questions, if you chose an option other than "not at all" from the questions above. If you have chosen "not at all" to both questions, you may skip to the next section.

How many days in the last two weeks have you been bothered by the below symptoms?

Trouble Falling or Staying Asleep	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Feeling Tired or Little Energy	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Difficulty Getting Along with Others	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Thoughts about Hurting Yourself	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Trouble Concentrating	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Poor Appetite or Overeating	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All
Feeling Bad about Yourself	◯ Not at all	◯ Rarely	◯ Half or More	◯ Nearly All

DOMESTIC VIOLENCE SCREENING

Have you ever been physically or emotionally abused by a partner? ☐ YES ☐ NO

Have you been physically hurt by someone in the last year? ☐ YES ☐ NO

Within the last year has someone forced you to have sexual activity? ☐ YES ☐ NO

If you have been diagnosed as having Diabetes, please let us know when your last testing was completed below.

Name of Test	Date Last Performed	Place Last Performed	If unknown, circle option:
Microalbumin			NOT SURE or NEVER
Hemoglobin A1C			NOT SURE or NEVER
Eye Exam			NOT SURE or NEVER
Foot Exam			NOT SURE or NEVER

IMMUNIZATIONS: Please check off any vaccinations you have had, please add the approximate date if known.

Vaccination:	Month /Year:	Vaccination:	Month /Year:
Flu Shot		Pneumonia	
Hepatitis A		Shingles	
Hepatitis B		Tetanus	
HPV		Tetanus w/Pertussis	
MMR		Varicella (Chicken Pox)	
Meningitis		Other:	

Have you had any of the following screening tests?

Screening test/Other test	Date	Location	Result (please circle)
Colonoscopy			Normal Abnormal
Dexa (Bone Density) Scan			Normal Abnormal
Mammogram			Normal Abnormal
Pap Smear			Normal Abnormal
Lipid Panel			Normal Abnormal
Aortic Aneurysm			Normal Abnormal

FUTURE PLANNING

Do you have an advance directive? YES or NO

If yes, does TFHC have a copy of it? YES or NO

If no, please provide a copy to TFHC for our records.

If you do not have an advance directive, do you wish to receive further information? YES or NO