MEDICAL HISTORY

PARKLAND FAMILY HEALTH CENTER **TODAY'S DATE _____/_____/_____**

NAME_____AGE_____DOB_____GENDER: ____M____F

OCCUPATION:_____PRIMARY PHONE:_____

CIRLE ONE: SINGLE MARRIED DIVORCED WIDOWED SEPERATED

ETHNICITY CIRLE ONE: ASIAN AFRICAN AMER HISPANIC WHITE OTHER: _____

SPOUSE'S NAME:_____

CHILDREN'S NAMES AND AGES:_____

NAME OF SPECIALITY DOCTORS SEEN	PHONE NUMBER	REASON WHY SEEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY CIRCLE BELOW IF YOU HAVE HAD ANY OF THE FOLLOWING:

High Blood Pressure	Thyroid Disease	TB	Unexplained Weight gain/loss
Diabetes	Anemia	Headaches	Anxiety
Cancer _____	Kidney Disease	Persistent Cough	Depression
Heart Disease	Kidney Stones	Colitis	Alcohol Abuse
Constipation	Difficulty Urinating	Pneumonia	Tobacco Use
Arthritis	Gall Bladder Disease	Swollen Ankles	Drug Abuse
Blood in Stool	Skin Disease	Rheumatic Fever	Other: _____
Ulcers	Blood Disorders	Asthma	Other: _____
Change in Bowel Habits	Elevated Cholesterol	Hemorrhoids	Other: _____

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING: (circle answer)

	NOT AT ALL	SEVERAL DAYS	MORE THAN 1/2 THE DAYS	EVERY DAY
• LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
• FEELING DOWN, DEPRESS OR HOPELESS	0	1	2	3
• FEELING NERVOUS, ANXIOUS OR ON EDGE	0	1	2	3
• BEING UNABLE TO STOP/CONTROL WORRYING	0	1	2	3

PREVENTION circle answer

Do you wear seat belts? Yes No If no, why not? _____

Have you had any FALLS within the last year? Yes No How Many? _____

Do you smoke? Yes No Former Type? _____

Do you drink alcohol? Yes No Type? _____

Do you drink caffeine? Yes No Type? _____

Do you use drugs? (marijuana, opioids, heroin, cocaine, crack, etc.) Yes No Type? _____

Are you at risk of getting AIDS? (do you use IV drugs, body fluid exposure, unsafe sexual practice) Yes No

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Yes No

Are you in a relationship where you have been physical hurt (kicked, punched, slapped, bruised) by your partner? Yes No

Are you afraid of your partner? Yes No

Organ donor? Yes No Living Will? Yes No

NAME_____ **TODAY'S DATE** _____/_____/_____

PLEASE LIST SURGERIES AND DATES:

OPERATIONS:_____ _____ _____ _____

HOSPITALIZATIONS OTHER THAN FOR SURGERY:_____

IMMUNIZATION HISTORY—HAVE YOU HAD:

Pneumonia	Yes	No	Refused	Date if known?_____
Flu Shot	Yes	No	Refused	Date if known? _____
Tetanus	Yes	No		Date if known? _____
Shingles	Yes	No		Date if known? _____

When was your last:

Physical Exam	_____	Prostate Exam	_____	Eye Exam	_____
Colonoscopy	_____	Cholesterol Check	_____	Dental Exam	_____

ALLERGIES TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? ____YES ____NO

(LIST NAMES and REACTION)

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

Has any member of your family (parents, grandparents, siblings, children) ever had the following:

	Which Family Member (Mother, Father, Grandparent, etc.)	Which side of the family Mother or Father side	Age Diagnosed
CANCER (include type)	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
HEART DISEASE	_____	_____	_____
DIABETES	_____	_____	_____
STROKE	_____	_____	_____
ANXIETY/DEPRESSION	_____	_____	_____
DRUG/ALCOHOL ADDICTION	_____	_____	_____
BLEEDING DISEASES	_____	_____	_____
GLAUCOMA	_____	_____	_____
OTHER	_____	_____	_____

MEDICATIONS: Please include prescribed, over the counter and vitamins with dosage and how taken.

_____ _____

_____ _____

_____ _____

OB/GYN HISTORY

Last Pap Smear Date _____

Mammogram Date _____

Age at onset of periods _____Frequency _____Length of Periods _____

Pregnancies _____Births _____ Miscarriages_____

Do you have:

Prolonged or abnormal bleeding?	Yes	No	Abnormal Discharge?	Yes	No
Leakage of urine?	Yes	No	History of Abnormal Pap?	Yes	No
Pelvic Pain?	Yes	No	Method of Birth Control?	_____	

THIS INFORMATION WILL BE USED BY YOUR PHYSICIAN AS PART OF YOUR CONFIDENTIAL MEDICAL RECORD.