Davood

Family Medicine

Personalized Care for every stage of Life

PATIENT HISTORY FORM

A confidential record will be kept in your doctors office. Information contained here will not be released to anyone without your authorization

Today's Date ____/_____/_____ **Date of Last Physical Exam_____/_____/_____**

LAST NAME:_____ FIRST NAME:_____

ETHNICITY_____ Date of Birth _____/_____/_____AGE_____

OCCUPATION_____ Marital Status Married___Single___Divorced___Widowed_____

MEDICAL(High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Number of Pregnacies_____ Number of Live Births_____

Method of Birth Control if any_____

SURGICAL(Tonsillectomy, Appendectomy, Hysterectomy, Hernia, ect)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES TO MEDICATION? YES___ NO___ (IF YES , PLEASE EXPLAIN TYPE OF REACTION)

CURRENT PRESCRIPTION MEDICINE **OVER THE COUNTER MEDICATION, (asprin ,Vitamins, Herbs,etc.**

Name of Drug:	mg dose,	#times per day	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need more room please use back of sheet or attach separate paper

FAMILY HISTORY

Father Living____ Age____ Deceased, Age at Death_____ (Cause)_____

Mother Living____ Age____ Deceased, Age at Death_____ (Cause)_____

Siblings: Number Living_____ Number Deceased_____ (Cause)_____

List other illnesses in your family (Example-Diabetes, heart disease, colon cancer, breast cancer, prostate cancer etc.

Family Member	Illness	Family Member	Illness	Family Memebr	Illness
_____	_____	_____	_____	_____	_____

Social History

Smoke? Yes____ No____ If yes, how much? _____# of packs/day_____When did you stop smoking_____

Alcohol? Yes____No____ If yes, how much?_____

Substance Abuse? Yes_____ No_____ If yes, what and how much_____

Exercise regularly? Yes_____ No_____ If yes, what and how frequently?_____

Routinely wear seatbelts? Yes_____ No_____ Wear Helmet when biking? Yes_____No_____

Review of Systems

Do you now or have you had any problems related to the following systems? write **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Last Eye & Dental Exam

Date - Last Eye Exam: _____
Date - Last Dental Exam: _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Sexual History

Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N

Other (i.e. sexual trauma)

Screening Exams

Cholesterol	Colonoscopy	Mammogram	Pelvic Exam
PSA	Chest X-ray	Stress Test	Blood Pressure