FAMILY PHYSICIANS GROUP, P.C.

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Date: _____

Dear Patient:

Please complete this Health History form prior to seeing your physician:

Name:_____ (Maiden Name)_____ Date of Birth:_____
Address: _____ City: _____ State: _____ Zip:_____

1. Please list MEDICATIONS, Both prescription and non- prescription:

Medication Name	Dose (mg)	How often	Reason

2. Please list ALLERGIES to medications, food and other. Also, describe type of reaction:

3. Please list SURGERIES and dates:

4. Please list other hospitalizations, major illnesses, injuries and dates:

_____

_____

_____

_____

5. Adult Vaccine Status

   Date of last: Tetanus _____ Pneumonia _____ Influenza _____

   Zostavax _____

6. Exercise History (Exercise Type and Frequency):

_____

_____

7. Do you drink alcoholic beverages: Yes _____ No _____ If yes, list as accurately as possible how many cans of beer, shots of whiskey or glasses of wine you drink per week:

_____

_____

8. Do you smoke/chew tobacco? Yes _____ No _____ If yes, how many packs per day?_____

   How many years? _____

   Have you ever smoked in the past? Yes _____ No _____ If yes, how many packs per day?_____

   How many years? _____

9. Do you use or abuse other substances or drugs? Yes _____ No _____

10. Family Medical History

    Mother: Age if living _____ Age at death if deceased _____ Cause of death _____

    Father: Age if living _____ Age at death if deceased _____ Cause of death _____

    Please list family members (parents, grandparents, uncles, aunts, brothers, sisters, children) who have the following:

    High Blood Pressure _____

    Heart Attack _____

    Heart Stents _____

    Diabetes _____

    Strokes _____

    Cancer (include type if known) _____

    Kidney Disease _____

    Asthma _____

    Thyroid _____

    Mental Disorder (include type if known)_____

    Other (illnesses not mentioned above) _____

    _____

NONE APPLY

REVIEW OF SYSTEMS

Please circle problems that affect you at the present time

Gene:	Appetite Loss	Fatigue	Fever	Obesity	Weight gain
Skin:	Mole change	Sweating	Itching	New lesion	Rash
Head:	Headache	Injury			
Eyes:	Color Blind	Double Vision	Vision Loss	Glaucoma	
Ears	Hearing Loss	Ear Pain	Ringing	Vertigo	
Nose/Throat	Runny Nose	Seas. Allergies	Sleep Apnea	Snoring	Sore Throat
Neck:	Stiffness	Swollen Glands			
Lungs:	Cough	Diffic. Breathing	Snoring		
Heart:	Abnormal BP Palpitations	Chest Pain Rapid Heart Rate	Fainting	Hypertension	Leg Pain
Gastro:	Abd. Pain Hemorrhoids	Bloody Stool Heartburn	Constipation Nausea	Diarrhea Rectal Bleeding	Food Intol Vomiting
Female:	Blood in Urine Painful Intercourse Vaginal Bleeding	Diff. Emptying	Discharge Painful Urination Vaginal Dryness	Frequency Painful Urination	Menstr. Irreg. Uri. Retention Urine Leakage
Male:	Blood in Urine Testicular Mass	E.D. Testicular Pain	Discharge Urgency	Incontinence Urination at Night	
Mus/Skl:	Back Pain	Joint Pain	Joint Swelling	Muscle Weakness	
Neuro:	Decr. Memory Loss of Consc.	Difficulty Speaking Stroke	Dizziness Tremor	Headaches Weakness	Incoordination Tingling
Psych:	Anxiety	Depression	Inab. To Concentr.	Insomnia	Memory Loss
Endo:	Appetite Change	Excessive Sweat	Excessive Urination	Libido Change	
Hemo:	Anemia	Easy Bruising	Excessive Bleeding	Painful Lymph Nodes	

Other: _____