COLLEGE PARK FAMILY PRACTICE MEDICAL HISTORY FORM

Name: _____ Date: _____

Current illnesses:_____

Previous illnesses:_____

Surgeries and procedures **/** year:

Appendectomy/	Wisdom teeth extraction/	Other/
Gallbladder surgery/	EKG/	
Hernia surgery/	Chest x-ray/	
Vasectomy/	Tetanus immunization/	
C-section/	PPD (tuberculosis test)/	

Other hospitalizations:_____

History of trauma, fractures, etc.:_____

Smoking history:

____ Never smoked or smoked for less than one year
____ Former smoker (___packs per day for ___years)
____ Current smoker (___packs per day)

Medication allergies (e.g. penicillin, sulfa, etc.) **/** reaction (hives, stomach upset, etc.)

Environmental allergies: (e.g. pollens, animals, fruits, foods, etc.) **/** reaction (rash, diarrhea, etc.)

Family history: (Heart attack, stroke, diabetes, high blood pressure, lung disease, etc.)

Father Mother	
Siblings	
Grandparents, aunts, uncles	

Preventative care: (check all that apply)

____ Appropriate seatbelt use
____ Working smoke detectors in the home

(Answer the following only if children are in the home:)

____ Firearms in the home
____ Firearm safety observed

Specialists (Names):

Dentist _____
Eyecare _____
Dermatologist _____
Gynecologist _____
Orthopaedist _____
Other_____

Social history:

- Occupation:_____

- Marital status:
  - ____ Unmarried
  - ____ Married
  - ____ Widowed
  - ____ Name of significant other: _____

- Children (names **/** ages):

- Alcoholic beverages:
  - ____ Nondrinker
  - ____ Rare
  - ____ Occasional/social
  - ____ Regular
  - ____ Daily

- Caffeinated beverages: (Coffee, tea, energy drinks, etc.)
  - ____ None or rarely
  - ____ Regularly (number per day ____)

- Exercise habits:

- Religious affiliation (Optional):

- Hobbies:

Current prescription medications: (Name and strength)

Current nonprescription medications:

Review of systems: (check all that apply)

____ Unexplained weight change, fatigue, fever, visual problems, ringing in ears or problem hearing.
____ Change in voice, sinus problems, nasal allergies, hay fever, or swelling in the neck.
____ Chest tightness or discomfort, palpitations, difficulty breathing, wheezing, or cough.
____ Varicose veins, poor circulation in your legs or pain in the legs with walking.
____ Heartburn, indigestion, nausea, constipation, diarrhea, abdominal pain or bloating.
____ Hemorrhoids, blood in your stools, black stools, or change in bowel movements.
____ Difficulty urinating, blood in urine, kidney stones, or excessive nighttime urination.
____ Joint pain, stiffness or swelling of the joints, chronic back or neck pain.
____ Moles or blemishes that have changed, lumps under the skin, rashes, hives, or eczema.
____ Recent hair loss, tattoos, or birthmarks.
____ Heat or cold intolerance, easy bruising, nosebleeds, bleeding gums, or enlarged glands.
____ Tremors, seizures, memory problems, unexplained anxiety, mood swings, or feeling down.
____ Trouble getting to sleep or staying asleep, excessive snoring, or constantly waking up tired.
____ Recent high risk sexual activity.
____ Family history of mental illness, addictions, or suicide.