FAMILY PRACTICE ASSOCIATES
PATIENT MEDICAL HISTORY

Name: _____ Preferred Name: _____ Age: _____

Occupation: _____ Date of Birth: _____ Marital Status: M S D W

Height: _____ Weight: _____ How Would You Describe Your General Health? _____

Do You Have a Regular Doctor? Y N Name: _____ Date of Last Physical Exam: _____

Do You See Any Specialists? Y N Name: _____ Do You Exercise? Y N _____

Do You Have Any Physical Limitations? _____ Advanced Directive? Y N _____

How Did You Hear About Our Clinic?/Person Who Referred You To Us: _____

What is the Reason For Today's Visit? _____

Have You Ever Had: *(Circle All That Apply)*

Arthritis Asthma/Lung Disease Blood Disease/Bleeding Disorder Cancer Diabetes Heart Disease/Heart Attack
High Blood Pressure High Cholesterol Kidney Disease Mental Illness Depression/Anxiety Seizures Stroke
Migraine Headaches Skin Disease Deafness/Blindness Gastric Ulcers/Acid Reflux HIV Tuberculosis STD

Please List Any Other Past Medical Problems:

_____ _____ _____

_____ _____ _____

Previous Surgeries/Hospitalizations Including Childbirth: *(List Year/Location/Doctor/Complications if Known):*

_____ _____ _____

_____ _____ _____

Family History of Any Diseases: *(List Affected Family Members)*

_____ _____ _____

_____ _____ _____

Current Medications and Doses: *(Including Over-the-Counter Meds, Birth Control pills, Vitamins, Herbal Meds, etc.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Known Drug Allergies: *(List Type of Reaction the Medication Caused You)*

_____ _____ _____

Do You Use:

Alcohol? Y N How Much/How Often Do You Drink? _____

Tobacco? Y N How Much Per Day Do You Smoke/Chew? _____ How Many Years? _____

Patient/Responsible Party Signature: _____ **Date:** _____

Physician Initials: _____ Date: _____

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