

Family Medicine of SayeBrook, LLC

PERSONAL HEALTH HISTORY

Name _____ Date _____

PAST MEDICAL HISTORY

High Blood Pressure [Y][N] Diabetes [Y][N] Heart Attack [Y][N]
 Thyroid Disease [Y][N] Anemia [Y][N] Heart Disease [Y][N]
 High Cholesterol [Y][N] Asthma [Y][N] Depression [Y][N]
 Hospitalization [Y][N] Why _____
 Other Illness [Y][N] List _____

PAST SURGERY

Appendix [Y][N] Other Surgeries [Y][N] _____
 Tonsils [Y][N] _____
 C-Section [Y][N] _____
 Gallbladder [Y][N] _____
 Hysterectomy [Y][N] _____

CURRENT MEDICATIONS

Medication Name	Dose	When Taken	Refills Needed
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]

Medication Allergies [Y][N] _____

FAMILY HISTORY

Heart Disease [Y][N] High Blood Pressure [Y][N] Diabetes [Y][N]
 Stroke [Y][N] Cancer [Y][N] Depression [Y][N]

WORK HISTORY

Current occupation _____
 History of exposure to chemicals, fumes, or asbestos _____
 Any job related injury [Y][N]
 Are you disabled [Y][N] Why? _____

SOCIAL HISTORY

Smoke [Y][N] How much? _____ packs/day Started _____ years ago Quit _____
 Alcohol [Y][N] How many drinks? _____ per day or week (circle one)
 Illegal Drugs [Y][N]
 History of Sexually Transmitted Disease [Y][N]
 Do you think you have any risk of AIDS [Y][N]

REVIEW OF SYSTEMS

Respiratory Tract

Chronic Cough [Y][N] Cough Blood [Y][N] Short of Breath [Y][N]
Sinus Trouble [Y][N] Allergy Shots [Y][N] Chest Pain [Y][N]

Heart and Blood Vessels

Chest Pain [Y][N] Prior Heart Attack [Y][N] Leg Pain with Walking [Y][N]
Palpitations [Y][N] Fluid in Legs [Y][N]

Gastrointestinal Tract

Heartburn [Y][N] Ulcers [Y][N] Hiatal Hernia [Y][N]
Chronic Nausea [Y][N] Cramping [Y][N] Poor Appetite [Y][N]
Chronic Diarrhea [Y][N] Blood in Stool [Y][N] Pain in Abdomen [Y][N]
Change in Stool [Y][N]

Skin and Nails

Chronic Rash [Y][N] New or Changing Moles [Y][N] Frequent sun exposure [Y][N]

Neurologic

Frequent Headache [Y][N] Migraines [Y][N] Numbness [Y][N]
Fainting [Y][N] Double vision [Y][N] Seizures in Past [Y][N]

Skeletal System

Joint Pain [Y][N] Broken Bones [Y][N] Sprained Joints [Y][N]
Back Pain [Y][N] Arthritis [Y][N]

Questions for MEN

Painful Urination [Y][N] Difficult Urination [Y][N] Blood in Urine [Y][N]
Penis Discharge [Y][N] Nighttime Urination [Y][N] Sexual Difficulty [Y][N]

Questions for Women

Painful Urination [Y][N] Difficult Urination [Y][N] Painful Menses [Y][N]
Irregular Menses [Y][N] Birth Control Pills [Y][N] Vaginal Discharge [Y][N]
Hot Flashes [Y][N] Sexual Difficulty [Y][N] Number of Pregnancies _____

Number of Children _____ Date of Last PAP _____
Age at First Menses _____ Date of Last Menses _____

General Questions

Difficulty Sleeping [Y][N] Loss of Enjoyment in Life [Y][N] Change in Appetite [Y][N]
Always Tired [Y][N] Always Hot or Cold [Y][N] Poor Concentration [Y][N]
Weight loss [Y][N] Weight Gain [Y][N]

ADDITIONAL INFORMATION

Any important information not asked above?
