**FAMILY MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ASTHMA | CANCER | DECEASED | DIABETES | HEART DISEASE | HIGH BP | NONE |
| MOTHER |  |  |  |  |  |  |  |
| FATHER |  |  |  |  |  |  |  |
| SISTER |  |  |  |  |  |  |  |
| BROTHER |  |  |  |  |  |  |  |

**SOCIAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HISTORY OF SMOKING? |  YES |  NO | HISTORY OF ALCOHOL? |  YES |  NO |
| CURRENT SMOKER? |  YES |  NO | CURRENT ALCOHOLIC? |  YES |  NO |
| YEARS SMOKED? |  | | ESTIMATED CAFFEINE INTAKE: | | |
| PACKS PER DAY SMOKED? |  | | HOW WOULD YOU DESCRIBE YOUR EXERCISE LEVEL? | | |
| DO YOU USE CHEWING TOBACCO? |  YES |  NO | DAYS OF MODERATE/STRENOUS EXERCISE IN LAST 7 DAYS: | | |
| ARE YOU EXPOSED TO SECOND HAND SMOKE? |  YES |  NO | HOW MANY MINUTES EACH DAY? | | |
| ILLICIT DRUG USE? |  YES |  NO | DIFFICULTY DRESSING OR BATHING? |  YES |  NO |
| DO YOU HAVE A SINGLE OR MULTI-LEVEL HOME/WORK? |  | | DIFFICULTY DOING ERRANDS ALONE? |  YES |  NO |
| DEAF OR HARD OF HEARING? |  YES |  NO | AMBULATORY? |  YES |  NO |
| BLIND/SERIOUS DIFFICULTY SEEING? |  YES |  NO | HIGHEST LEVEL OF EDUCATION COMPLETED: | | |
| DIFFICULTY CONCENTRATING? |  YES |  NO | SEXUALLY ACTIVE? |  YES |  NO |
| DIFFICULTY REMEMBERING? |  YES |  NO | SEXUAL ORIENTATION? |  | |
| DIFFICULTY MAKING DECISIONS? |  YES |  NO | GUNS PRESENT IN HOME? |  YES |  NO |
| DIFFICULTY WALKING OR CLIMBING STAIRS? |  YES |  NO | SMOKE ALARM IN HOME? |  YES |  NO |
| ENROLLED IN HOSPICE? |  YES |  NO | ARE YOU STRESSED OR ANXIOUS? |  YES |  NO |
| SUNSCREEN USED ROUTINELY? |  YES |  NO | DO YOU HAVE AND ADVANCE DIRECTIVE? |  YES |  NO |
| SEAT BELTS USED ROUTINELY? |  YES |  NO | DO YOU LIVE ALONE OR WITH OTHERS? | | |
| HISTORY OF OVERSEAS TRAVEL? |  YES |  NO | ARE YOU EMPLOYED? |  YES |  NO |
| CHILDERN? |  YES |  NO | OCCUPATION: | | |
| NUMBER OF CHILDERN: |  | | DO YOU EAT A HEALTHY WELL BALANCED DIET? |  YES |  NO |

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| ARE YOU ALLERGIC TO ANY MEDICATIONS?  YES  NO |
| PLEASE LIST: |

**PERSONAL MEDICAL HISTORY**

*\*PLEASE CHECK ALL THAT APPLY*

 ADD/ADHD  AIDS/HIV  ALCOHOLISM  ARTHRITIS  ANEMIA

 ABUSE/DOMESTIC VIOLENCE  ALLERGIES  ANESTHESIA COMPLICATIONS

 ANXIETY  ASTHMA  AUTISM SPECTRUM DISORDER (ASD)  BACK PAIN

 BEDWETTING  BIRTH DEFECTS  BLOOD CLOTS  BRONCHITIS  CANCER

 BLOOD DISEASES  BLADDER/KIDNEY PROBLEMS  BREAST CANCER  COPD

 BLOOD TRANSFUSION  BREAST PROBLEMS  CHICKEN POX  CONSITPATION  DIABETES

 CHRONIC EAR INFECTIONS  CONGESTIVE HEART FAILURE (CHF)  DEPRESSION

 CORONARY ARTERY DISEASE  DEVELOPMENTAL/BEHAVIORAL DISORDERS  DIVERTICULITIS

 DIFFICULTY SWALLOWING  EAR INFECTIONS  EAR/HEARING PROBLEMS

 EATING DISORDERS  ECZEMA  ENDOMETRIOSIS  FIBROMYALGIA  GI PROBLEMS

 GERD/ULCERS  GOUT  HEADACHES  HEART DISEASE  HEPATITIS

 HEART PROBLEMS  HEART DIESASE  HYPERLIPIDEMIA  HYPERTHYROIDISM  INFERTILITY

 HYPOTHYROIDISM  HOSPITALIZATIONS  HYPERTENSION  KIDNEY DISEASE  MIGRAINES

 KIDNEY STONES  LIVER DISEASE  LUNG DISEASE  MRSA EXPOSURE  OBESITY

 MENIERE’S DISEASE  MENTAL DISORDER  MENTAL ILLNESS  MUSCLE, JOINT, OR BONE PROBLEMS

 OSTEOPOROSIS  OVARIAN CANCER  POLYPS  PRE-ECLAMPSIA  VARICOSITIES

 PULMONARY EMBOLISM  SEIZURES  PROSTATE DISEASE  SKIN PROBLEMS  STROKE

 THROMBOPHILIAS  THYROID PROBLEMS  TUBERCULOSIS  VISION/EYE PROBLEMS

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| --- | --- | --- |
| **CURRENT MEDICATIONS**  (PRESCRIPTION, OVER THE COUNTER, SUPPLEMENTS) | | |
| NAME OF MEDICATION | STRENGTH(MG) | DIRECTIONS |
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| NONE  | | |