**URBAN FAMILY PRACTICE ASSOCIATES, P.C.**

 **PATIENT MEDICAL HISTORY FORM**  **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONCERNS/QUESTIONS REGARDING YOUR HEALTH THAT YOU WOULD LIKE ADDRESSED TODAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL PROBLEMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU HEARING IMPAIRED? ꙱ YES ꙱ NO ARE YOU VISUALLY IMPAIRED? ꙱ YES ꙱ NO**

**PREVIOUS SURGERY & HOSPITALIZATIONS: (include procedure and date)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS: 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(prescriptions, over the counter,**

**vitamins, herbals, supplements) 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMUNIZATIONS: (YEAR) Tetanus Booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HPV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Measles/Mumps/Rubella \_\_\_\_\_\_\_ Prevnar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Influenza \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Hepatitis A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Chicken Pox/Varicella \_\_\_\_\_\_\_\_\_\_ Zostavax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Shingrix **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE LIST ALL PHYSICIANS YOU HAVE SEEN IN THE PAST YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF LAST COLONOSCOPY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY: (List medical problems; Examples: hypertension, diabetes, heart disease, cancer)**

 **AGE MEDICAL PROBLEMS**

**MOTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FATHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BROTHER(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SISTER(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILDREN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MATERNAL GRANDPARENTS \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATERNAL GRANDPARENTS \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YOUR OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYED ꙱ UNEMPLOYED ꙱ RETIRED ꙱**

**MARITAL STATUS: SINGLE ꙱ MARRIED ꙱ DIVORCED ꙱ WIDOWED ꙱ SIGNIFICANT OTHER ꙱**

**HABITS/SOCIAL HISTORY:**

**TOBACCO: \_\_\_\_\_\_\_ # PACKS/PER DAY \_\_\_\_\_\_\_ HOW LONG (years) Previously quit YES ꙱ NO ꙱**

**ALCOHOL: HOW MANY DRINKS PER DAY? \_\_\_\_\_\_\_\_\_\_\_ HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DRUGS: (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW MUCH CAFFEINE DO YOU DRINK PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU EXERCISE REGULARLY? YES ꙱ NO ꙱ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU FOLLOW A SPECIAL DIET? YES ꙱ NO ꙱ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU REGULARLY WEAR A SEATBELT? YES ꙱ NO ꙱ How often? \_\_\_\_\_\_\_\_\_\_\_\_**

**ANY HISTORY OF HIGH RISK SEXUAL BEHAVIOR? YES ꙱ NO ꙱**

**WOULD YOU LIKE TO BE SCREENED FOR STDS? YES ꙱ NO ꙱**

**Over the last two weeks, how often have you been bothered by any of the following problems?**

 **Not at all Several days More than Nearly**

 **½ the days Every Day**

1. **Little interest or pleasure in doing things 0 1 2 3**
2. **Feeling down, depressed or hopeless 0 1 2 3**

 **Do you feel lonely or socially isolated? ꙱ YES ꙱ NO**

**\*We offer patient resources on our website: www.urbanfamilypractice.org**

**REVIEW OF SYSTEMS: (Please check off any problems you currently have)**

**꙱ skin rash ꙱ history of tuberculosis ꙱ discharge (urethra/vagina)**

**꙱ skin growth ꙱ chest pain ꙱ genital herpes**

**꙱ headaches/migraines ꙱ palpitations (extra heartbeats) ꙱ history of venereal warts**

**꙱ visual problems ꙱ history of heart murmur ꙱ HIV**

**꙱ loss of vision ꙱ rheumatic fever ꙱ joint pain or swelling**

**꙱ hearing loss ꙱ heart attack/myocardial infraction ꙱ convulsions or seizures**

**꙱ ringing in ears ꙱ high blood pressure ꙱ dizziness**

**꙱ nosebleeds ꙱ ulcer ꙱ depression**

**꙱ nasal drainage ꙱ persistent indigestion ꙱ anxiety**

**꙱ hay fever or allergies ꙱ constipation ꙱ problems handling stress ꙱ sinus problems ꙱ diarrhea ꙱ difficulty sleeping**

**꙱ difficulty swallowing ꙱ hemorrhoids ꙱ weight loss or gain**

**꙱ recurrent strep throat ꙱ blood in stool ꙱ change in sexual interest**

**꙱ persistent gland swelling ꙱ hepatitis ꙱ bleeding disorder**

**꙱ goiter (enlarged thyroid) ꙱ urinary tract infections ꙱ bruising easily**

**꙱ shortness of breath ꙱ urinary incontinence ꙱ history of blood clots**

**꙱ asthma/wheezing ꙱ pain with urination ꙱ previous blood transfusion**

**꙱ persistent cough/bronchitis ꙱ kidney stones ꙱ fatigue/lack of energy**

**FEMALE PATIENTS:**

**Year of the onset of menstrual periods \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pregnancies \_\_\_\_\_\_ Live Births \_\_\_\_\_\_ Miscarriages \_\_\_\_\_\_ Abortions \_\_\_\_\_\_**

**Method of birth control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last pap \_\_\_\_\_\_\_\_\_\_\_ History of abnormal pap? YES ꙱ NO ꙱**

 **When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**