# North Suburban Family Medicine

In order to ensure that we are aware of your complete medical history and to better assess your individual risk factors, please take a few minutes to answer these questions.

Name: _____ Date: _____

Date of Birth: _____ Spouse/Significant Other: _____

**Other Household Members**: (Name, age, and relation)

_____

_____

| Health History | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Check (v) all items either No or Yes** | **No** | **Yes, Now** | **Yes, Past** | **Check (v) all items either No or Yes** | **No** | **Yes, Now** | **Yes, Past** |
| Abnormal EKG | | | | Headaches (Frequent) | | | |
| Alcoholism | | | | Heart Attack or Heart Disease | | | |
| Anemia or Low Blood | | | | Heart Murmur | | | |
| Anxiety | | | | Hemorrhoids or Rectal Problems | | | |
| Arthritis or Sore Joints | | | | Hepatitis Type A, B or C (circle) | | | |
| Asthma or Hay Fever | | | | Hernia | | | |
| Bleeding or Bruising | | | | High Blood Pressure | | | |
| Broken Bones | | | | High Cholesterol | | | |
| Bronchitis or Emphysema | | | | HIV/AIDS | | | |
| Cancer | | | | Jaundice | | | |
| Cataracts | | | | Kidney or Bladder Problems | | | |
| Chemical Dependency | | | | Leg or Foot Pain | | | |
| Chest Pain | | | | Liver Disease | | | |
| Circulation Problems | | | | Night Sweats | | | |
| Deafness or Dizziness or Ringing Ears | | | | Phlebitis or Blood Clots | | | |
| Depression or Sadness | | | | Psychiatric Care | | | |
| Diabetes | | | | Sexually Transmitted Disease | | | |
| Difficulty Sleeping or Lie Awake at Night | | | | Shortness of Breath | | | |
| Ear Infections | | | | Sinus Trouble | | | |
| Epilepsy or Seizures | | | | Skin Disease or Psoriasis or Eczema | | | |
| Fatigue or Tiredness or Weakness | | | | Stomach Problems or Ulcers | | | |
| Forgetful | | | | Stool or Bowel Problems | | | |
| Gall Stones | | | | Stroke | | | |
| Glaucoma | | | | Thyroid Problem | | | |
| Gout | | | | Tuberculosis or Positive TB Test | | | |
| Head Injury | | | | Weight Loss or Gain (circle one) | | | |

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**Previous Surgeries or Hospitalizations**: (please state year)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

**Health Maintenance**: (most recent, please give month and year if known)

Flu vaccine: _____ Pneumococcal Vaccine: _____ Tetanus: _____ Stress Test: _____

PSA (prostate): _____ Colonoscopy: _____ Pap test: _____

Mammogram: _____ Last menstrual period: _____

**Medications**: (include over the counters, herbals, supplements, and vitamins)

| Name of Medication | Dose | Directions |
|---|---|---|
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| | | |
| | | |

**Allergies**: (medication, food, and environmental). Please include the reaction.

1. _____ 2. _____

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**Social History**:

Are you: Married _____ Domestic Partner _____ Single _____ Divorced _____ Widowed _____

Occupation: _____ Employer: _____

Do you smoke? Y/N Type: _____ Packs/day: _____ Years smoked: _____

Do you drink alcohol? Y/N Type: _____ Amount: _____ Frequency: _____

Do you use illicit drugs? Y/N Have you used illicit drugs in the past? Y/N

Type: _____ Route: _____ Amount: _____ Frequency: _____ Last Use: _____

Do you have concerns for eating disorders? Y/N Domestic Violence? Y/N

**Family History**: (relation, age at diagnosis; if deceased, age at time of death)

Heart Disease: _____ High Blood Pressure: _____

Heart Failure: _____ High Cholesterol: _____

Stroke: _____ Aneurysm: _____

Poor Circulation: _____ Amputation: _____

Emphysema: _____ Asthma: _____

COPD: _____ Chronic Bronchitis: _____

Cancer (type): _____ Oxygen used at home: _____

Diabetes: _____ Thyroid Disease: _____

Liver Disease: _____ Hepatitis: _____

Kidney Disease: _____ Kidney Failure: _____

Dementia: _____ Arthritis: _____

Other: _____

_____

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**Review of Symptoms**: (circle all the symptoms that you have been experiencing)

**Cardiac**: chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur

**Lungs**: shortness of breath, chronic cough, coughing up blood, wheezing

**GI**: nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, blood in your stool, black tarry stools, abdominal pain, pelvic pain, heart burn, indigestion, acid reflux

**GU**: difficulty urinating, blood in urine, pain with urination, urinary incontinence, frequent urination, waking at night to urinate, bedwetting, daytime wetting

**Reproductive**: vaginal discharge, vaginal itching, heavy/painful/irregular periods, penile discharge,
Age of first period _____ Last menstrual period _____

**Muscular**: Swelling in legs, chronic joint pain (If yes, which joint _____), back pain (chronic, recurrent), muscle aches, muscle deformity

**Skin**: lumps, bumps, moles of concern, rash, sores/lesions

**Neurological**: numbness, tingling, tremor, seizure, convulsions, headaches (migraine, tension, cluster, sinus)

**Eyes**: vision loss, blurred vision, double vision, blindness
Wears: Glasses _____ Contacts _____ To drive/To read/All the time

**Ears**: hearing loss, vertigo, ringing in the ears, hearing aid (right/left/both), failed hearing screening

**Nose**: bloody nose, obstruction, deviated septum, snoring, post nasal drip

**Throat**: sore throat, lump in throat, change in voice, difficulty swallowing

**Psych**: depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation

**General**: fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep

**Other**: _____

_____