URBAN FAMILY PRACTICE ASSOCIATES, P.C.
PATIENT MEDICAL HISTORY

DATE _____

NAME _____ DATE OF BIRTH _____ AGE: _____

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

_____

_____

PAST MEDICAL PROBLEMS: _____

_____

_____

PREVIOUS SURGERIES & HOSPITALIZATIONS: (Include procedure and date)

_____

_____

DRUG ALLERGIES: _____

MEDICATIONS: 1._____ 3._____ 5._____

(Prescription,over the counter, 2._____ 4._____ 6._____

herbals, vitamins, supplements)

IMMUNIZATIONS: (YEAR) Tetanus booster _____

Measles/ Mumps/ Rubella _____

Influenza _____ Pneumovax _____

Hepatitis A _____ Hepatitis B _____

Chicken Pox/ Varicella _____

Please list all physicians you have seen in the past year:

_____

FAMILY HISTORY: (List medical problems – including hypertension, diabetes, heart disease, cancer)

	AGE	MEDICAL PROBLEMS
Mother		
Father		
Brother(s)		
Sister(s)		
Children		
Maternal Grandparents		
Paternal Grandparents		

OCCUPATION: _____

MARITAL STATUS: Single _____ Married _____ Divorced _____ Widowed _____ Significant Other _____

(OVER)

HABITS/ SOCIAL HISTORY:

TOBACCO: _____ packs/ day _____ years. Previously quit (Y / N)

ALCOHOL: How many drinks per day: _____ How often? _____

DRUGS (list): _____

Do you exercise regularly? (Frequency, form) _____

Do you follow a special diet? _____

Do you regularly wear a seatbelt? _____

How much caffeine do you drink per day? _____

Any history of high risk sexual behavior? _____

Would you like to be screened for STD's? _____

REVIEW OF SYSTEMS: Please check off or write any problems which you CURRENTLY have:

_____ skin rash
_____ skin growth
_____ headaches / migraines
_____ visual problems
_____ loss of vision
_____ hearing loss
_____ ringing in ears
_____ nosebleeds
_____ nasal drainage
_____ history of hay fever/ allergies
_____ sinus problems
_____ difficulty swallowing
_____ recurrent strep throats
_____ persistent gland swelling
_____ goiter (enlarged thyroid)
_____ shortness of breath
_____ wheezing/ asthma
_____ persistent cough/ bronchitis
_____ history of tuberculosis
_____ chest pain
_____ palpitations (extra heartbeats)
_____ history of heart murmur
_____ rheumatic fever
_____ heart attack/ myocardial infraction
_____ high blood pressure
_____ ulcer
_____ persistent indigestion

_____ constipation
_____ diarrhea
_____ hemorrhoids
_____ blood in stool
_____ hepatitis
_____ urinary tract infections
_____ urinary incontinence
_____ pain with urination
_____ kidney stones
_____ discharge (urethral/vagina)
_____ genital herpes
_____ history of venereal warts
_____ HIV
_____ joint pain or swelling
_____ convulsion or seizure
_____ dizziness
_____ depression
_____ anxiety
_____ problems handling stress
_____ difficulty sleeping
_____ significant weight loss or gain
_____ change in sexual interest or vigor
_____ bleeding disorder
_____ easy bruising
_____ history of blood clots
_____ previous blood transfusion
_____ fatigue / lack of energy

FEMALE PATIENTS:

Age of onset of menstrual periods _____ Last menstrual period _____

# of Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Method of birth control _____ Date of last mammogram _____

Date of last Pap test _____ History of abnormal Pap test _____