

Fairlawn Family Practice Patient Health History Form

Label

| | | | | | |
|-------------------------|--|--------------------------------------|---------------------------------------|---|----------------------------------|
| Name | | | | Today's Date | |
| Gender (Sex) | <input type="checkbox"/> Male | <input type="checkbox"/> Female | Age | Birth Date (mm/dd/yyyy) | |
| Marital Status | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| Currently Living | <input type="checkbox"/> Alone | <input type="checkbox"/> With Family | <input type="checkbox"/> With Friends | <input type="checkbox"/> With Significant Other | |
| Profession (Job) | <input type="checkbox"/> Working, Employed By: | | | | <input type="checkbox"/> Retired |

| 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) | | | |

| Habits | | | Medications | |
|-----------------------|--|--------------------------|---|-----|
| Do you: | | If Yes, how much? | Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.) | |
| Smoke Tobacco | <input type="checkbox"/> No <input type="checkbox"/> Yes | Packs/Day | 1. | 8. |
| Chew Tobacco | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tins or Bags/Day | 2. | 9. |
| Drink Caffeine | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cups/Day | 3. | 10. |
| Drink Alcohol or Wine | <input type="checkbox"/> No <input type="checkbox"/> Yes | Drinks/Day | 4. | 11. |
| Drink Beer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cans/Day | 5. | 12. |
| Gamble | <input type="checkbox"/> No <input type="checkbox"/> Yes | | 6. | 13. |
| Use Street Drugs | <input type="checkbox"/> No <input type="checkbox"/> Yes | | 7. | 14. |
| Exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |

Immunizations

| | | |
|-------------|--|------|
| Flu Shot | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
| Hepatitis B | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
| MMR | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
| Pneumonia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
| Tetanus | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |

Allergies

List anything that you are allergic to (medications, foods, bee sting, etc.) and how each affects you.

| | |
|----|-----------|
| 1. | Reaction: |
| 2. | Reaction: |
| 3. | Reaction: |
| 4. | Reaction: |
| 5. | Reaction: |

Hospitalizations (not including normal pregnancies)

| | |
|----|------|
| 1. | Year |
| 2. | Year |
| 3. | Year |
| 4. | Year |

Serious Illness (not requiring hospitalization)

| | |
|----|------|
| 1. | Year |
| 2. | Year |
| 3. | Year |
| 4. | Year |

Family History

| Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed. | Father | Mother | Brother | Sister | Son | Daughter | Grandparent | Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed. | Father | Mother | Brother | Sister | Son | Daughter | Grandparent |
|--|--|--------|---------|--------|-----|----------|-------------|--|--|--------|---------|--------|-----|----------|-------------|
| | | | | | | | | | | | | | | | |
| Alcoholism | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Leukemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Liver Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Asthma or Hay Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Mental Illness | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Birth Defects | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Migraines | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Nervous Breakdown | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Colon or Bowel Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Obesity | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Congenital Heart Defects | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Sickle Cell Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Emphysema | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Stomach Problems or Ulcer | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |

Men Only

| | |
|--|--|
| Pain or lump(s) in testicles? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Penile (penis) itching, burning or discharge? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Prostate disease or problems? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Problems starting or stopping your urine stream? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Wake in the night to go to the bathroom? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sexual problems or concerns? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you feel safe in your home? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have a Living Will? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Where? | |
| If No, would you like information on Living Wills? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Women Only

| | | | |
|--|--|-----------|--|
| Last Pap Smear | | Abnormal? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Last Mammogram | | Abnormal? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Age Periods Started | | Problems? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ovarian Cysts | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sexual problems or concerns? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Vaginal itching, burning or discharge? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Wake in the night to go to the bathroom? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Breast disease or nipple discharge? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Pregnancies | # | Births | # |
| Miscarriages | # | Abortions | # |
| Birth Control Method: | | | |
| Do you feel safe in your home? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have a Living Will? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Where? | |
| If No, would you like information on Living Wills? | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |

The information on this Patient Health History Form is correct to the best of my knowledge.

Patient or Guardian Signature _____ Date _____

Physician Signature _____ Date _____