

Family History (cont.)

(Circle "no" or "yes", leave blank if uncertain)

			Relationship	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Glaucoma	no	yes	_____	Father_____	_____
Gout	no	yes	_____	Mother_____	_____
Heart Disease	no	yes	_____	Siblings	_____
High blood pressure	no	yes	=====		
High Cholesterol	no	yes	_____		
Kidney Disease	no	yes	_____		
Leukemia	no	yes	_____	Spouse	_____
Mental Illness	no	yes	_____	Children	_____
Migraine headaches	no	yes	_____		
Obesity	no	yes	_____		
Stroke	no	yes	_____		
Thyroid Disease	no	yes	_____		
Tuberculosis	no	yes	_____		
Ulcer	no	yes	_____		

Do you have now or have you had within the past year:

(Circle "no" or "yes", leave blank if uncertain)

Peristent fever	no	yes	Shortness of breath	no	yes	Joint pain or stiffness	no	yes
Change in appetite	no	yes	Wheezing	no	yes	Swollen joints	no	yes
Recent weight changes	no	yes	Bloody sputum	no	yes	Muscle cramps or spasms	no	yes
Tire easily or weakness	no	yes	Nausea	no	yes	Backaches	no	yes
Weakness or paralysis	no	yes	Vomiting	no	yes	Lack of sex drive	no	yes
Eye pain	no	yes	Chronic diarrhea	no	yes	Night sweats or hot flashes	no	yes
Double vision	no	yes	Chronic constipation	no	yes	Sensitivity to cold or hot	no	yes
Blurred vision	no	yes	Heartburn	no	yes	Depression	no	yes
Changes in vision	no	yes	Frequent belching	no	yes	Sleeplessness	no	yes
Infected eyes	no	yes	Abdominal cramping	no	yes	Easy bleeding	no	yes
Wearing glasses or contacts	no	yes	Yellow jaundice	no	yes	Easy bruising	no	yes
Headaches	no	yes	Black tarry stools	no	yes	Dizziness or fainting spells	no	yes
Sinus trouble	no	yes	Hemorrhoids	no	yes	Men only:		
Frequent nosebleeds	no	yes	Vomited or coughed up blood	no	yes	Discharge from penis	no	yes
Sore throat	no	yes	Rectal bleeding	no	yes	Pain or lump in testicles	no	yes
Ringing in the ears	no	yes	Difficulty swallowing	no	yes	Impotence	no	yes
Discharge from ears	no	yes	Frequent urination (day)	no	yes	Women only:		
Ear pain	no	yes	Frequent urination (night)	no	yes	Age period began	_____	
Decrease in hearing	no	yes	Dark urine	no	yes	How many days do periods last?	_____	
Frequent colds	no	yes	Increase in thirst	no	yes	How many days between periods?	_____	
Loss of smell	no	yes	Painful urination	no	yes	Is the flow heavy?	no	yes
Persistent hoarseness	no	yes	Leakage of urine	no	yes	Do you bleed or spot	no	yes
Sore tongue or gums	no	yes	Difficulty in starting urine	no	yes	between periods?		
Lump or discharge from breast	no	yes	Blood in urine	no	yes	Do you have pain or cramps?	no	yes
Chest pain or discomfort	no	yes	Skin rash	no	yes	Date of last period?	_____	
Purple fingers or lips	no	yes	Hair growth change	no	yes	Date of last pelvic exam?	_____	
Swelling of hands, feet or ankles	no	yes	Nail changes	no	yes	Date of last mammogram?	_____	
Difficulty breathing	no	yes	Skin trouble or changes	no	yes	Any itching in vaginal area?	no	yes
Palpitations or fluttering of the heart	no	yes	Poor coordination	no	yes	Pain with intercourse?	no	yes
Leg cramps on walking or at night	no	yes	Memory loss	no	yes	Type of birth control used?		
Enlarged veins	no	yes	Seizures	no	yes	Number of pregnancies		
						Number of full term births	_____	
						Number of preterm births	_____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X

Signature of patient or parent if minor

Date

Physician's Comment

Physician's Signature