FAMILY HEALTH CARE
a balanced approach to family health and well being

Name: ______________________ Date of Birth: __________ Age: __________ Date: __________

Occupation: ______________ PT/FT Marital Status: ________ Number & Age of Children: ______________

Chief Concern for Today's Visit: ______________________________

ONGOING HEALTH CONCERNS (Include all you take medication for.)

	Yes	No	Medication		Yes	No	Medication
Diabetes	☐	☐		Cancer	☐	☐	
Heart Disease	☐	☐		High BP	☐	☐	
Stroke	☐	☐		Kidney Disease	☐	☐	
Asthma	☐	☐		Emphysema	☐	☐	
Other	☐	☐		Please Describe:			

ALLERGIES

SURGERIES/HOSPITALIZATIONS (and dates):

HABITS

Alcoholic Drinks/Week:		Coffee/Caffeine/Day:		Water/Day:	
Exercise Routine:		Hours Sleep/Night:		Mg Calcium/Day:	
Tobacco Products/Day:		Interested in Stopping:		BM/Day:	

MEDICATIONS (Please Include vitamins, supplements & over-the-counter products.)

Name	Dose	Frequency	Name	Dose	Frequency

HEALTH MAINTENANCE HISTORY

	Date	Normal	Abnormal		Date	Normal	Abnormal
Last Complete Physical		☐	☐	Last Bone Density Study		☐	☐
Last Blood Work		☐	☐	Last Colonoscopy		☐	☐
Last Cholesterol Check		☐	☐	Last Flu Vaccine		☐	☐
Last Pap Smear		☐	☐	Last Tetanus Injection		☐	☐
Last Mammogram		☐	☐	Other:		☐	☐

HISTORY

Constitutional	Currently	In the past	No
Weight Stable	☐	☐	☐
Fatigue	☐	☐	☐
Hair Loss	☐	☐	☐
Appetite Changes	☐	☐	☐
Memory Changes	☐	☐	☐
Sleeping Problems	☐	☐	☐
Eyes			
Vision Changes	☐	☐	☐
Eye Infections	☐	☐	☐
Eye Pain	☐	☐	☐
Ear/Nose/Throat			
Ear Infections	☐	☐	☐
Nose Bleeds	☐	☐	☐
Hearing Problems	☐	☐	☐
Ear Pain	☐	☐	☐
Ringing in Ears	☐	☐	☐
Sore Throat	☐	☐	☐
Swallowing Problems	☐	☐	☐

Cardiovascular	Currently	In the past	No
Chest Pain	☐	☐	☐
Murmur	☐	☐	☐
Palpitations	☐	☐	☐
Swelling in Legs	☐	☐	☐
Respiratory			
Short of Breath	☐	☐	☐
Cough	☐	☐	☐
Wheezing	☐	☐	☐
GI			
Abdominal Pain	☐	☐	☐
BM Habit Changes	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐
Heartburn	☐	☐	☐
Hepatitis	☐	☐	☐
Diarrhea	☐	☐	☐

GU	Currently	In the past	No
Urinary Leaking	☐	☐	☐
Decrease force/flow	☐	☐	☐
Vaginal Discharge	☐	☐	☐
Irregular Periods	☐	☐	☐
1st day of last period:			
# days between periods:			
# days of flow:			
Number of Pregnancies:			
Painful Intercourse	☐	☐	☐
Testicular Pain	☐	☐	☐
Breasts			
Lumps of Concern	☐	☐	☐
Tenderness	☐	☐	☐
Skin			
Rashes	☐	☐	☐
Psoriasis	☐	☐	☐
Eczema	☐	☐	☐
Acne	☐	☐	☐

HISTORY (cont.)

Musculoskeletal	Currently	In the past	No
Joint Pain	☐	☐	☐
Arthritis	☐	☐	☐
Recurrent Back Pain	☐	☐	☐
Foot Pain	☐	☐	☐
Gout	☐	☐	☐
Osteoporosis	☐	☐	☐
Muscle Weakness	☐	☐	☐

Neurologic	Currently	In the past	No
Fainting	☐	☐	☐
Frequent Headaches	☐	☐	☐
Seizures	☐	☐	☐
Tremors	☐	☐	☐
Numbness/tingling	☐	☐	☐
Endocrine	☐	☐	☐
Diabetes			
Thyroid Problems	☐	☐	☐

Hematologic/Lymphatic	Currently	In the past	No
Anemia	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐
Psychiatric			
Mental Illness	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Allergies			
Hay Fever	☐	☐	☐
Immune Problems	☐	☐	☐

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High BP	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

ADDITIONAL PROVIDERS

Provider Name	Specialty/What they treat you for	Date of Last Visit	Phone Number

FOR OFFICE USE ONLY

Date/Initial____________	Date/Initial____________	Date/Initial____________	Date/Initial____________
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