Rockbridge Family Medicine

NAME:_____ BIRTH DATE: ___/___/____ DATE:___/___/___

Occupation: _____ Date of Last Phys Exam _____ Eye Exam_____

PLEASE SPECIFY TYPES OF MAJOR ILLNESSES WHERE THEY APPLY

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
ADD – ADHD			Heart Attack / Angina		
Anemia / Sickle Cell			Heart Murmur		
Arthritis / Joint pain			Hemorrhoids / Rectal Problems		
Asthma			Hepatitis A, B, C		
Bipolar Disorder / OCD / Phobias			High Blood Pressure		
Blood or Clotting Disorder			High Cholesterol / Triglycerides		
Bowel Trouble/Diverticulitis/Colitis			Jaundice / Elevated Liver Enzymes / Liver Problems		
Cancer – Type?			Lupus / Connective tissue disease		
Chronic Lung Disease			Kidney Infections / Stones / Bladder Problems		
Colon Polyps/Colon Cancer			Pancreatitis		
Congestive Heart Failure			Pneumonia		
Depression / Anxiety / Mood Disorders			Rheumatic Fever or Heart Valve Problems		
Diabetes – Type 1 or Type 2 (**CIRCLE TYPE**)			Sexually Transmitted Diseases		
Emphysema / COPD			Sleep Apnea / Excessive Snoring		
Fibromyalgia			Suicide Attempt / Nervous Breakdown		
Gallbladder Problems / Stones			Stroke / TIA ("mini-stroke")		
Gestational Diabetes			Thyroid Disease		
GI / Rectal Bleeding			Tuberculosis		
Glaucoma / Eye Disorders			Ulcers		
Gout / Other Joint Disease			Varicose Veins / Phlebitis / Clots		
OTHER:			OTHER:		

LAST TEST OR IMMUNIZATION

Immunizations	DATE	**Tests**	DATE
Chicken Pox		Bone Density	
Flu Shot		Mammogram / Breast Ultrasound	
Hepatitis A / B		Back or Neck X-Ray	
Meningitis		Chest X-Ray	
MMR		CT Scan or MRI – of what? For what?	
Pneumonia		Barium Swallow / Barium Enema	
Tetanus		Colonoscopy	
OTHER:		Gallbladder / Abdominal Ultrasound	
		Upper Endoscopy	
		Angioplasty or Cardiac Catheterization	
		Echocardiogram (Heart Ultrasound)	
		EKG (Electrocardiogram)	
TB Skin Test:		Heart Stress Test (Treadmill)	
		PSA	

INJURIES

TYPE	DATE	TYPE	DATE

OPERATIONS / HOSPITALIZATIONS

SURGERY / REASON	DATE	SURGERY / REASON	DATE
Appendectomy		Neck or Back Surgery	
Cholecystectomy (Gallbladder)		Tonsillectomy	
Heart Surgery		Tubal Ligation or Vasectomy	
Hernia Repair – Groin, Bellybutton		OTHER:	
Hysterectomy with/without Ovaries removed?			

CURRENT PERSCRIBED MEDICATIONS

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
OTC & Herbal Medications					
Tylenol			Advil / Aleve / Ibuprofen		
Aspirin / Bayer / Goodies			Sleeping Aids		
Herbs / Vitamins / Supplements			Decongestants / Nasal Spray		
Appetite Suppressants			Laxatives		

ALLERGIES

Drug:		Food:		Environment:	
Drug Name	Reaction	Name	Reaction	Name	Reaction

FAMILY MEDICAL HISTORY

(F – Father, M = Mother, B = Brother, S = Sister, C = Child,
PGF = Paternal Grandfather, PGM = Paternal Grandmother, MGF = Maternal Grandfather, MGM = Maternal Grandmother)

MAJOR ILLNESSES	**Who**		**Who**
Alcoholism / Addiction		High Blood Pressure / Hypertension	
Anemia / Blood or Clotting Disorder		High Cholesterol / Triglycerides	
Aneurysm – Where?		Irritable / Inflammatory Bowel Syndrome	
Arthritis / Joint Problems		Kidney Problem / Stones	
Asthma / Seasonal Allergies		Lupus / Connective Tissue disease	
Blood Clots in Legs (DVT) / or Lungs (PE)		Mental Illness / Bipolar	
Cancer – List types		Migraine Headaches	
Colon or Rectal Polyps		Osteoporosis / Osteopenia	
Depression / Suicide		Seizures / Epilepsy	
Diabetes – Type 1 or 2		Stroke / TIA ("mini-stroke")	
Emphysema / COPD / Lung Problems		Thyroid Problems / Goiter	
Endometriosis / Uterine Fibroids		Tuberculosis	
Genetic Disorders / Birth Defects		OTHER:	
Glaucoma / Eye disorders			
Heart Attack / Heart Failure / Arrhythmia			

SOCIAL HISTORY

HABITS – Safety	YES	NO	**Habits – Health (continued)**	YES	NO
Firearms in home or access to firearms?			Smoking?		
Seatbelt Use?			Packs per day: Years:		
Wear bicycle / motorcycle helmet?			Take Calcium?		
Work with blood or body fluids?					
Habits – Health			**Habits - Sexual**		
Alcohol Use?			Sexually Active?		
Drinks/day: Drinks/week:			Anal Intercourse?		
Arrested for DUI or Public Intoxication?			First Intercourse – Age:		
Blood Transfusion before 1992?			HIV Test?		
Chew or Dip Tobacco?			Result:		
Drink Caffeinated Beverages?			Lifetime sexual partners: ◻ less than 5 ◻ more than 5		
Drinks/day: Drinks/week:			New Sexual Partner:		
Drink Milk?			Sexual Orientation		
Glasses/day:			◻ Heterosexual ◻ Homosexual ◻ Bisexual		
Eat Cheese/Other Dairy Products?			Syphilis?		
Servings/day:			Chlamydia?		
Exercise?			Gonorrhea?		
◻ None ◻ Less than 3/week ◻ More than 3/week			Genital Warts?		
Exposed to Second – hand smoke?					
History of Abuse?					
◻ Physical ◻ Emotional ◻ Sexual					
Problems at work/with family because of drinking?					
Recreational Drugs or IV Drugs?					
Kind:					

Women Only: OB – Gyn History

Menstrual	**YES**	**NO**	**Pregnancy**
Do you use birth control?			
◻ Oral ◻ Barrier ◻ Injection ◻ Tubal Ligation ◻ Vasectomy			Total # of pregnancies:
◻ Natural Family Planning ◻ IUD ◻ OTHER:			Premature:
Last Menstrual Period (date):			Miscarriages:
Typical Flow: ◻ Light ◻ Medium ◻ Heavy			Full term births:
First Period: Age:			Abortions Induced:
Menopause?			Living Children:
Menopause Age:			
On Hormone Replacement Therapy?			
HRT Type:			