Family Practice Associates

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Name: _____ Age: ____ Date of Birth: __ /__ /__ Sex: M / F Date: _____
Address: _____ Phone: _____
Marital Status: Married / Divorced / Single / Widowed Occupation: _____
Chief Complaint: _____
_____

Past Medical History:

Heart Trouble	Yes	No	Epilepsy (seizures)	Yes	No
Hypertension	Yes	No	Gout	Yes	No
Kidney Trouble	Yes	No	Stroke	Yes	No
Arthritis	Yes	No	Obesity	Yes	No
Diabetes Mellitus	Yes	No	Problems with feet, legs, knees, hips, back, other	Yes	No
Cancer	Yes	No			

Comments: _____
_____

Past History: Surgery / Trauma	Year	Hospital	Physician

Comments: _____
_____

Childhood Diseases

Measles	Yes	No	Rheumatic Fever	Yes	No
Mumps	Yes	No	Frequent Sore Throats	Yes	No
Chicken Pox	Yes	No	Frequent Ear Infections	Yes	No
Scarlet Fever	Yes	No	Other _____		

Medications (Currently Taking)

Name	Amount	Taken? (i.e. one twice a day)
1.		
2.		
3.		

Please write on back if additional space is needed.

Allergies	Yes	No	If yes, allergic to what?
1.			
2.			
3.			

Blood Transfusions: Yes / No If yes, why? _____

Social History: Date and place of birth: _____
Where were you raised: _____ Religion: _____
Hobbies & Special Interests: _____
Education Completed: Elementary / High School / College / Post Graduate / Other: _____

Family History	Current Age	Living? Or cause of death?	Major Health Problems (heart disease, stroke, cancer, diabetes, arthritis, etc)
Mother			
Father			
Children			
(additional children)			
Spouse			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Brother(s)			
Sister(s)			
Aunt(s)			
Uncle(s)			

1. Do you have any family history of heart disease, strokes, or sudden death below the age of 50? Yes__ No__
2. Do you have a strong family history of heart disease, strokes, cancer, or sudden death between 50-65? Yes__No__

Lifestyle

1. **Smoke:** No__ Yes__. If yes, ____ packs/ day for ___ years. (If you have smoked in the past, quit date: _____ .)
2. **Alcohol:** No___ Yes___. If yes: rarely___ occasionally___ daily___.
3. **Sleep Habits:** Number of hours per day____. Do you rest well? Yes___ No___
4. **Physical Activity:**
    a. Do you consider your level of physical activity adequate? Yes___ No___
    b. Do you engage in vigorous exercise at least 3 times per week? Yes___ No___
    c. Does your job involve strenuous or heavy labor? Yes___ No___
    d. What is your favorite form of exercise? _____
    e. Do you know how to count your pulse? Yes___ No___
5. **Nutrition:**
    a. Frequency of meals per day 1___ 2___ 3___ More ___
    b. Your typical meal includes: Breakfast: _____
    Lunch: _____
    Dinner: _____
    c. Do you limit sugars, fats, or salt? No___ If Yes, circle which you limit.
    d. Recent weight gain or loss (greater than 10lbs in 3 months) No__ If yes, circle gain or loss; how much?___
6. **Stress:**
    a. Your present level of stress: minimal___ moderate___ large___
    b. Do you <u>almost always</u> move, walk, and eat rapidly? Yes___ No___
    c. Do you usually attempt to do two or more things at once? Yes___ No___
    d. Do you find it difficult to relax? Yes___ No___
    e. Do you find it difficult to fall asleep? Yes___ No___
    f. Have you had several major changes in the past year? (new home, job change, death of relative) Yes___ No___