GRANDVIEW FAMILY MEDICINE

CURRENT PATIENT HEALTH HISTORY FORM

Today's date: _____/ _____/ _____

Name: _____ Birthdate: _____/ _____/ _____
Last First Middle

MEDICAL HISTORY

Check major, **significant illnesses** which apply to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Cancer(s)_____
- ☐ Celiac Disease
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes (Type _____)
- ☐ Eating Disorder
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Epilepsy/Seizures
- ☐ Heartburn/GERD
- ☐ Heart Problems_____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Genetic Disorder
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Mental Illness_____
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ PCOS
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis/TB
- ☐ Ulcers
- ☐ Other:_____

SURGICAL/HOSPITAL

List the year of any Operations/Procedures you have had (if year unknown just ✓):

	Year		Year
Appendix surgery	_____	Hip surgery	_____
Back Surgery	_____	Hysterectomy	_____
Breast growth removal	_____	Knee Surgery	_____
Carpal tunnel	_____	Nasal/Sinus Surgery	_____
C-Section Delivery	_____	Plastic Surgery_____	_____
Colonoscopy	_____	Polyp Removed from Intestine	_____
D & C	_____	Prostate Surgery	_____
Eye Surgery	_____	Shoulder Surgery	_____
Foot/Ankle Surgery	_____	Thyroid surgery	_____
Gall Bladder Removal	_____	Tonsils removed	_____
Gastroscopy	_____	Tubal Ligation	_____
Heart Surgery	_____	Vasectomy	_____
Hernia	_____	Other_____	_____

List any **Broken Bones/Serious Accidents:**

_____ Year(s): _____

MEDICATIONS

List all medications you are currently taking (including inhalers) and all over the counter drugs, vitamins or herbs.
Please list prescribed medications first:

Name of Medicine / Dose / Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES

Medications: Reactions:

_____ _____
_____ _____
_____ _____

Animals: _____ Reactions:_____

☐ Latex ☐ Tape ☐ Iodine ☐ Pollens ☐ Perfume ☐ Peanuts ☐ Gluten ☐ Milk ☐ Egg

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

List the cause of death for those who have died prior to age 50 (Do not include accidental deaths)

Father _____ Mother's Father _____ Father's Father _____
Mother _____ Mother's Mother _____ Father's Mother _____

Fill in any blood relatives that have any of the following illnesses: brother (b), sister (s), mother (m), father (f) or maternal grandparents (mother's side) m(gf), m(gm), or paternal grandparents (father's side) p(gf), p(gm).

☐ Alcoholism	_____	☐ Emotional/Mental Illness	_____
☐ Alzheimer's/Dementia	_____	☐ High Blood Pressure	_____
☐ Anxiety	_____	☐ Heart Attack prior to age 55	_____
☐ Cancer (Breast)	_____	☐ Heart Disease	_____
☐ Cancer (Prostate)	_____	☐ High Cholesterol	_____
☐ Cancer (Lung)	_____	☐ Osteoporosis	_____
☐ Cancer_____	_____	☐ Stroke	_____
☐ Depression	_____	☐ Substance Abuse	_____
☐ Diabetes (type_____)	_____	☐ Thyroid Disease	_____

SOCIAL HISTORY

1. Occupation: _____ 2. Your sex: ☐ Female ☐ Male
3. Marital Status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced ☐ Widowed
4. Race: ☐ Caucasian ☐ Hispanic ☐ Indian ☐ African American ☐ Asian ☐ Polynesian/Island ☐ Other: _____
5. Number of children: Number of Sons _____ Number of Daughters _____ Miscarriages/Abortions _____
6. Have you had extensive travel outside the United States (other than vacation) ☐ Yes ☐ No
7. What is your **smoking** status? ☐ Non-Smoker ☐ Past ☐ Current
8. On average how many **alcoholic drinks** do you consume during one day? ☐ Non-drinker ☐ 1-2 ☐ 3 or more
9. Do you follow a **special diet**? ☐ Yes ☐ No
10. How many days per week do you **exercise** for at least 30 minutes? ☐0 ☐1-2 ☐3-5 ☐6-7
11. Do you need help from your doctor for an issue related to illegal **drugs**? ☐ Yes ☐ No
12. Do you need help from your doctor for a problem related to physical, verbal, or mental abuse? ☐ Yes ☐ No
13. Are you at risk for AIDS/(HIV)? ☐ Yes ☐ No
    (Homosexual, Bisexual, Multiple sex partners, needle drug use other than insulin)