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Raintree Family Medicine | 997 Raintree Circle, Suite 150 | Allen, Texas 75013-4954

**How did you hear about us?** _____

**CONFIDENTIAL PERSONAL MEDICAL HISTORY – INITIAL**

**DATE COMPLETED/SUBMITTED TO OFFFICE:** _____

NAME _____ AGE _____ DATE OF BIRTH_____

PLEASE CIRCLE ANY ITEMS THAT APPLY TO YOU, ANSWER THE QUESTIONS, AND FILL IN ALL THE BLANKS.
Don't forget page 4.

MAJOR MEDICAL PROBLEM(S) _____

PURPOSE OF EXAM: ROUTINE PERIODIC OR PRESENT MEDICAL PROBLEMS (DESCRIBE BELOW)

**DESCRIBE YOUR AVERAGE DAY (YOUR TYPICAL SCHEDULE):** I wake up at _____. I go to work at _____. I return home at _____. I go to bed at _____. My daily activities include work / exercise / study / other (describe): _____
_____.

DATE OF: LAST PHYSICAL _____ CHEST X-RAY _____ BONE MINERAL DENSITY TEST _____

PAP SMEAR _____ LAB/BLOOD TESTS _____ PROSTATE EXAM _____

EKG _____ COLONOSCOPY _____ MAMMOGRAM _____

**PAST MEDICAL HISTORY:**

CHILDHOOD DISEASES – MEASLES, MUMPS, RUBELLA (GERMAN MEASLES), CHICKEN POX, RHEUMATIC FEVER, CONGENITAL BIRTH DEFECTS, HEART MURMUR

ILLNESSES AT ANY AGE – KIDNEY DISEASE, PNEUMONIA, TUBERCULOSIS, LIVER DISEASE/HEPATITIS/ JAUNDICE, DIABETES, HIGH BLOOD PRESSURE, THYROID DISEASE, STROKE, CANCER, GLAUCOMA, HEART DISEASE/HEART ATTACK/ANGINA, HIGH CHOLESTEROL, HIV/AIDS VIRUS, ANEMIA, DEMENTIA/ALZHEIMER'S, DEPRESSION, ANXIETY/PANIC DISORDER.

**SERIOUS INJURIES/TRAUMA/ACCIDENTS/BROKEN BONES:**

| DATE | INJURY | PROBLEM NOW? |
|---|---|---|

**HOSPITALIZATION/OPERATIONS:**

| DATE | ILLNESS/OPERATION | COMPLICATION? |
|---|---|---|

**IMMUNIZATIONS:** DATE OF: LAST TETANUS _____ PNEUMOVAX _____
TB SKIN TEST _____ POSITIVE NEGATIVE

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?
YES NO WHEN? _____ ANY REACTION? _____

DO YOU HAVE ANY ALLERGIES (RASH OR TROUBLE BREATHING) TO MEDICATIONS? YES NO

| MEDICINE | REACTION |
|---|---|

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**CONFIDENTIAL PERSONAL MEDICAL HISTORY – INITIAL**

**PATIENT NAME:** _____

**CURRENT MEDICINES:** (INCLUDE BIRTH CONTROL PILLS, VITAMINS AND OVER-THE-COUNTER DRUGS)

| DRUG | SIZE/MG | HOW OFTEN? |
|---|---|---|

**FAMILY HISTORY:** (List all these relatives, living or not, regardless of health status.)

| | **IF LIVING** AGE/HEALTH/MAJOR MEDICAL PROBLEMS | **IF DECEASED** AGE AT DEATH/CAUSE OF DEATH |
|---|---|---|
| FATHER | | |
| MOTHER | | |
| BROTHERS | | |
| | | |
| | | |
| SISTERS | | |
| | | |
| | | |

| | NAME | BIRTHDATE | HEALTH (IF LIVING) OR CAUSE OF DEATH/AGE AT DEATH |
|---|---|---|---|
| SPOUSE | | | |
| SONS | | | |
| | | | |
| | | | |
| DAUGHTERS | | | |
| | | | |
| | | | |

**HAVE ANY OF YOUR BLOOD RELATIVES (Grandparents, Parents, Aunts, Uncles, Siblings, Children) HAD (List as Maternal or Paternal):**

| DISEASE/CONDITION | WHO | DISEASE/CONDITION | WHO |
|---|---|---|---|
| MENTAL ILLNESS | | CANCER/LEUKEMIA | |
| DEPRESSION | | BLEEDING TENDENCY | |
| SUICIDE | | HEMOPHILIA | |
| SICKLE CELL DISEASE/TRAIT | | DIABETES | |
| ASTHMA/SEVERE ALLERGIES | | HEART ATTACK | |
| STROKE | | EPILEPSY/SEIZURES | |
| MIGRAINE/SICK HEADACHE | | GALLSTONES | |
| ALZHEIMER'S | | EXTREMELY OVERWEIGHT | |

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**How did you hear about us?** _____

## INITIAL SOCIAL HISTORY

**DATE COMPLETED/SUBMITTED TO OFFFICE:** _____

**PATIENT NAME:** _____

OCCUPATION _____ I LIVE ALONE WITH _____

**TOBACCO:**

☐ NEVER SMOKED ☐ SMOKE NOW: PIPE CIGARS CIGARETTES _____ PACKS PER DAY FOR _____YRS
☐ DID SMOKE BUT QUIT (DATE _____) ☐WAS ___ PACK(S) PER DAY FOR _ YEARS
☐ DIP SNUFF ☐ CHEW AMOUNT _____ ☐ I WOULD LIKE TO STOP USING TOBACCO

**ALCOHOL:**

☐ NEVER DRANK ☐ DRINK NOW – AMOUNT OF BEER/WINE/LIQUOR PER DAY/WEEK/MONTH _____
☐ DID DRINK BUT QUIT (DATE _____)
WAS _____ (AMOUNT OF BEER/WINE/LIQUOR PER DAY/WEEK/MONTH
HAVE YOU EVER HAD A DRINKING PROBLEM THAT AFFECTED YOUR JOB OR A RELATIONSHIP? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN: _____

**RECREATIONAL/NON-MEDICINAL DRUG USE:** ☐ NONE
☐ USING NOW – DRUG _____ HOW OFTEN? _____
☐ USED BEFORE BUT QUIT (DATE _____) ☐ WAS USING _____ HOW OFTEN? _____
DID YOUR DRUG USE AFFECT YOUR JOB OR A RELATIONSHIP? ☐ YES ☐ NO

**HIV STATUS:** ☐ UNKNOWN TESTED ON (DATE _____) AND WAS ☐ NEGATIVE ☐ POSITIVE
SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ BISEXUAL ☐ GAY/LESBIAN

**HEALTHY LIFESTYLE:**

COFFEE/TEA/SOFT DRINKS: _____ PER DAY
DO YOU USE SEAT BELTS? ☐ YES ☐ NO
DO YOU GET REGULAR EXERCISE? ☐ YES ☐ NO TYPE? _____ HOW OFTEN? _____
HOW MANY MINUTES PER SESSION? _____

**DIET:** ARE YOU ON ANY SPECIAL DIET? ☐ YES ☐ NO NAME OF DIET: _____
DO YOU CONSIDER IT WELL-BALANCED AND HEALTHY? ☐ YES ☐ NO

**REVIEW OF SYSTEMS** (Circle all that apply)

**GENERAL:**
Weight is: Over, Under, About Right
If overweight, goal weight is _____
Fatigue, Weakness, Tired
Unplanned Weight Loss ____ in ___ Months
Fever, Chills, Night Sweats
Change in appetite, Insomnia
Have you ever been a victim of physical, Sexual or verbal abuse?

**NOSE/THROAT/SINUSES:**
Frequent nose bleeds
Frequent or persistent sore throat
Hoarseness, Post-nasal drip
Frequent sinus infections
Mouth ulcers
injury, swelling

**SKIN/HAIR/NAILS:**
Change in lesion, Bleeding, Bruising
Rash, Itching, Infection
Change in hair/ nails
Color change

**HEAD/FACE:**
Headache (if severe, ask for separate survey
Head Injury
Dizziness, Lightheadedness
Vertigo, Spinning
Loss of Balance
Facial Pain, Drooping

**EARS:**
Pain, Fullness, Congestion,
Ringing, Deafness

**TEETH:**
Problems?
Last Dental Visit? _____

**RESPIRATORY:**
Chronic cough/sputum
clear white colored
Shortness of breath
Asthma, Wheezing, Pleurisy
Coughing up blood

**EYES:**
Vision Good, Fair, Poor
Blurred, Double, Pain
Color Blindness, Tears, Dryness
Spots, shapes, Jagged Lines
Date of last eye exam _____
Date glasses changed _____
Is prescription still good? _____
Date of eye pressure (glaucoma check) _____

**BREAST:**
Lumps, Pain, Discharge
Do you examine your breasts?
(Women) ☐ Yes ☐ No

**MUSCLE/BONE/JOINT:**
Joint pain, redness, stiffness,
Which joints are affected? _____
_____
Bone or back deformity
Muscle weakness, tenderness

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# INITIAL SOCIAL HISTORY

**DATE COMPLETED/SUBMITTED TO OFFFICE:** _____

**PATIENT NAME:** _____

## GENITAL SYSTEM (FEMALE)

Age at onset of periods _____
Age at stopping periods _____
Periods are
☐ Regular ☐ Irregular,
Every _____ days
Periods last _____ days
Menstrual Pain, Cramps
Vaginal Discharge, Itching Now? ☐ Yes ☐ No
Method of birth control: None IUD
Foam Sponge Pill for _____ years
Tubal ligation Vasectomy Condoms
Loss of interest in sex
Are you satisfied with the frequency and quality of your sex life? ☐ Yes ☐ No
Frequent vaginal infections
# of pregnancies _____ # of children _____
Miscarriages/Abortions _____
History of Abnormal Pap Smear ☐ Yes ☐ No
If so, when? _____

## GASTROINTESTINAL

Nausea, vomiting, gas
Difficulty swallowing
Constipation, Diarrhea
History of ulcer(s)
Vomiting blood
Abdominal pain, hemorrhoids
Jaundice/Hepatitis (Type _____)
Heartburn/Indigestion

## HEART/CIRCULATION

Chest pain (sharp, dull, stabbing, burning pressure)
Neck/Jaw Pain, Nausea, Sweating
Arm Pain, related to exercise, meals, emotion, (duration _____)
Shortness of breath on exertion
After walking _____ blocks
After climbing _____ flights of stairs
Lying down or at night
Swelling of Feet or Ankles
Palpitations or fluttering
Heart Murmur, high blood pressure
Varicose veins
Passing out
Calves hurt when walking
Fingers/Toes hurt in cold
History of thrombophlebitis/blood clots
History of Rheumatic Fever

## GENITAL SYSTEM (MALE)

Testicle pain, swelling
Discharge/drip, sores
History of V.D.
What % of time that you want to have an erection are you able to get one? _____
What % of the time can you maintain it? _____
Are you satisfied with the quality of your sex life? _____

## URINARY TRACT

Discomfort on urination
Blood in urine
Stones
Excess frequency, urgency
Stream less forceful/smaller
Hard to start/stop stream
History of prostate trouble
History of treatment for V.D.
Do you lose control of urine if you cough, laugh or sneeze ☐ Yes ☐ No
How many times a night do you have to urinate? _____

## PSYCHIATRIC/ADJUSTMENT

Memory change, fatigue, anxiety
Depression, social withdrawal
Loss of appetite, Hallucinations
Crying spells, irritability, hopelessness
Thoughts of suicide
Difficulty with work, Panic attacks
Hard to fall asleep/frequent awakening

## ENDOCRINE/GLANDS/HORMONES

Goiter/Enlarged thyroid
Hyper or Hypo Thyroid
Heat or cold intolerance
Excessive water drinking, too frequent urination
Excessive or inadequate sweating
Unplanned weight loss or gain
Abnormal hair growth on body
Infertility

## NERVOUS SYSTEM

Seizures, convulsions, stroke
Weakness, tremors, shakes
Speech problems
Numbness, tingling
Trouble walking
Blind spells
Changes in sensation or coordination

THIS SPACE RESERVED FOR MEDICAL ASSISTANT OR PHYSICIAN USE