Grand Canyon Family Medicine, P.C.

3960 East Riggs Rd. Ste. 1
Chandler, AZ 85249
Phone: 480-786-4441
Fax: 480-786-4609

Health History (confidential)

Patient Name:_____ Today's Date:_____

Age:_____ Date of Birth:_____ Date of last physical exam:_____

What is your reason for today's visit:_____

SYMPTOMS: (circle current symptoms)

General:
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss Of Weight
Nervousness
Numbness
Sweats

Muscle/Joint or Bone:
Pain, weakness, numbness in:
arms hips back legs feet neck hands shoulders

Genito-Urinary:
Blood in Urine
Frequent Urination
Lack of Bladder Control
Painful Urination

Gastrointestinal:
Poor Appetite
Bloating
Bowel Changes
Constipation
Diarrhea
Gas
Hemorrhoids
Nausea/Vomiting
Rectal Bleeding
Stomach Pain

Skin:
Bruise easily
Itching
Rash
Sore that won't heal
Change in Moles

Cardio Vascular:
Chest Pain
High Blood Pressure
Low Blood Pressure
Irregular Heart Beat
Poor Circulation
Swelling of Ankles
Varicose Veins

Eyes, Ears, Nose, Throat:
Bleeding Gums
Blurred Vision
Difficulty swallowing
Double Vision
Earache
Ear Discharge
Hay Fever
Hoarseness
Loss of Hearing
Nosebleeds
Persistent Cough
Ringing in ears
Sinus Problems
Vision-Flashes/Halos

Men Only:
Breast Lump
Erection Difficulties
Lump in Testicles
Penis Discharge
Sore on Penis
Date of last Colonoscopy:_____
OTHER:_____

Women Only:
Abnormal Pap Smear
Bleeding Between Periods
Breast Lump
Extreme Menstrual Pain
Hot Flashes
Nipple Discharge
Painful Intercourse
Vaginal Discharge
Date of Last Period:_____
Date of Last Pap:_____
Date of Last Mammo:_____
Pregnant: Yes No
# of Pregnancies: _____
Pregnancy Complications: _____ _____
# of Children: _____
Date of Last Colonoscopy:_____
OTHER:_____

CONDITIONS: (circle conditions you currently have or have had)

Acid Reflux	Chemical Dependency	High Cholesterol	Prostate Problem
AIDS	Chicken Pox	HIV	Psychiatric Care
Alcoholism	Diabetes	Hypertension	Scarlet Fever
Allergies	Emphysema/COPD	Kidney Disease	Shingles
Anemia	Epilepsy	Liver Disease	Sleep Disorder
Aneurysm	Glaucoma	Measles	Stroke
Anorexia	Goiter	Migraine Headaches	Suicide Attempt
Arthritis	Gonorrhea/Chlamydia	Mononucleosis	Thyroid Problems
Asthma	Gout	Mumps	Tuberculosis
Bleeding Disorders	Heart Disease	Multiple Sclerosis	Ulcers
Bulimia	Hepatitis A B C	Pacemaker	Vaginal Infections
Cancer	Hernia	Pneumonia	Venereal Disease/STD
Cataracts	Herpes	Polio	Other:_____

Pharmacy & Address:_____ _____ _____

Phone:_____ _____ _____

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Medications:	Drug Allergies/Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: (Fill in health information about your family)

Relation	Age	Health Problems	Cause of Death	Check if your blood relative had any of the following: Disease : Relation to You
Father				Asthma, Hay Fever
Mother				Cancer (type)
Brothers				Chemical Dependency
				Diabetes (type)
				Heart Disease, Strokes
Sisters				Kidney Disease
				Tuberculosis
				Other:

Hospitalizations/Surgeries:

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? Yes No
If yes, please give approximate date _____

Health Habits: (check which substances you use & describe how much you use)

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Occupational: (check if your work exposes you to the following)

	Stress		Hazardous Substances
	Heavy Lifting		Other:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date