Patient Past Medical, Social & Family History

INSTRUCTIONS: Complete the following information by placing a check mark (√) in the appropriate boxes or by PRINTING the requested information. DO NOT write in the shaded areas labeled "For Medical Team Use Only."

Today's Date _____/_____/_____
(Month/Day/Year)

Patient Name

_____
(Last) (First) (M.I.)

Social Security # ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth _____/_____/_____ Sex: ❑ Male ❑ Female
(Month/Day/Year)

Who completed this form? ❑ Patient ❑ Spouse ❑ Other (specify)

_____

Name (if other than patient)

_____

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Past Medical History

Have you ever been hospitalized? ❑ No ❑ Yes

Have you had any serious injuries and/or broken bones? ❑ No ❑ Yes → Describe

_____

Have you ever received a blood transfusion? ❑ Unknown ❑ No ❑ Yes → Approximate year(s) _____

Have you ever traveled or lived outside the United States or Canada? ❑ No ❑ Yes → When and where _____

Have you received the following IMMUNIZATIONS? If yes, indicate the approximate year it was last given:

Pneumococcal (for pneumonia)	❑ Unknown	❑ No	❑ Yes	Year_____	Measles	❑ Unknown	❑ No	❑ Yes	Year_____
Hepatitis A	❑ Unknown	❑ No	❑ Yes	Year_____	Mumps	❑ Unknown	❑ No	❑ Yes	Year_____
Hepatitis B	❑ Unknown	❑ No	❑ Yes	Year_____	Rubella	❑ Unknown	❑ No	❑ Yes	Year_____
Tetanus/Diphtheria within last 10 years	❑ Unknown	❑ No	❑ Yes	Year_____	Polio	❑ Unknown	❑ No	❑ Yes	Year_____
Influenza (flu)	❑ Unknown	❑ No	❑ Yes	Year_____					

Have you ever had any of the following?	No	Yes	Describe the problem when appropriate	For Medical Team Use Only
1. Abnormal chest x-ray	❑	❑		
2. Anesthesia complications	❑	❑		
3. Anxiety, depression or mental illness	❑	❑		
4. Blood problems (abnormal bleeding, anemia, high or low white count)	❑	❑		
5. Diabetes	❑	❑		
6. Growth removed from the colon or rectum (polyp or tumor)	❑	❑		
7. High blood pressure	❑	❑		
8. High cholesterol or triglycerides	❑	❑		
9. Sexually transmitted disease	❑	❑		
10. Stroke or TIA	❑	❑		
11. Treatment for alcohol and/or drug abuse	❑	❑		
12. Tuberculosis or positive tuberculin skin test	❑	❑		
13. Cosmetic or plastic surgery	❑	❑		

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (√) in the appropriate boxes. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Describe	For Medical Team Use Only
1. Eyes (cataracts, glaucoma)	❑	❑	❑			
2. Ears, nose, sinuses, or tonsils	❑	❑	❑			
3. Thyroid or parathyroid glands	❑	❑	❑			
4. Heart valves or abnormal heart rhythm	❑	❑	❑			
5. Coronary (heart) arteries (angina)	❑	❑	❑			
6. Arteries (aorta, arteries to head, arms, legs)	❑	❑	❑			
7. Veins or blood clots in the veins	❑	❑	❑			
8. Lungs	❑	❑	❑			
9. Esophagus or stomach (ulcer)	❑	❑	❑			
10. Bowel (small & large intestine)	❑	❑	❑			
11. Appendix	❑	❑	❑			
12. Liver or gallbladder (including hepatitis)	❑	❑	❑			
13. Hernia	❑	❑	❑			
14. Kidneys or bladder	❑	❑	❑			
15. Bones, joints or muscles	❑	❑	❑			
16. Back, neck or spine	❑	❑	❑			
17. Brain	❑	❑	❑			
18. Skin	❑	❑	❑			
19. Breasts	❑	❑	❑			
20. **Females:** uterus, tubes, ovaries	❑	❑	❑			
21. **Males:** prostate, penis, testes, vasectomy	❑	❑	❑			
22. Other: Describe	❑	❑	❑			

Social History

Education: How many years of school have you completed? _____

Occupations: Your current employment status: ❑ Retired ❑ Unemployed ❑ Homemaker ❑ Employed – current occupation(s): _____

Previous Occupations/Jobs: _____

Disability: Are you disabled? ❑ No ❑ Yes → _____

Abuse: Have you ever been physically, sexually, or emotionally abused? ❑ No ❑ Yes → _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long? (Years)	If stopped, when? (Year)
Caffeine: coffee, tea, soda	❑ No ❑ Yes	❑ No ❑ Yes			
Tobacco	❑ No ❑ Yes	❑ No ❑ Yes			
Alcohol – beer, wine, liquor	❑ No ❑ Yes	❑ No ❑ Yes			
Recreational/Street drugs	❑ No ❑ Yes	❑ No ❑ Yes			

Marital Status: Are you currently married? ❑ No ❑ Yes → In what year did this marriage occur? _____

List any previous marriages (year married and duration): _____

Current Spouse Information: ❑ Not applicable ❑ Alive (Age _____) ❑ Deceased

Health problems or cause of death: _____

If alive, current employment status: ❑ Retired ❑ Unemployed ❑ Homemaker ❑ Employed – current occupation(s): _____

Family History

Are you adopted? ❑ Yes → If known, complete the following information about your **blood** relatives (include children). Exclude adoptive parents, siblings and adopted children.

❑ No → Complete the following information about your **blood** relatives. Exclude adoptive siblings and adopted children.

Father ❑ Alive (Age _____) ❑ Deceased (Age _____) ❑ Unknown **Cause of Death**: _____ ❑ Unknown

Mother ❑ Alive (Age _____) ❑ Deceased (Age _____) ❑ Unknown **Cause of Death**: _____ ❑ Unknown

	Number Alive	Approximate Age(s)	Number Deceased	Approximate Age(s) at Death	Cause(s) of Death	
Brothers	_____	_____	_____	_____	_____	❑ Unknown
Sisters	_____	_____	_____	_____	_____	❑ Unknown
Sons	_____	_____	_____	_____	_____	❑ Unknown
Daughters	_____	_____	_____	_____	_____	❑ Unknown

Place a check mark (√) in the appropriate boxes to identify all illnesses/conditions **which you know have occurred** in your **blood relatives**. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness or condition.

Illness/Condition	Family Members: Grandparents	Father	Mother	Brothers	Sisters	Sons	Daughters	None	Describe
Cancer (describe the type of cancer for each person)									
Heart Disease									
Diabetes									
Stroke/TIA									
High Blood Pressure									
High Cholesterol or Triglycerides									
Liver Disease									
Alcohol or Drug Abuse									
Anxiety, Depression or Psychiatric Illness									
Tuberculosis									
Anesthesia Complications									
Genetic Disorder									
Other – describe									
Other – describe									
Other - describe									

Other information about your family which you want us to know: _____

Healthcare Provider Information

Do you have a Primary Care Provider? ❑ No ❑ Yes → Name _____ Phone (____) _____

(prior)

Address _____

Medications

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications?
❑ No ❑ Yes → List medications below:

Name of Medication	Dose	How Often Taken

Are there other medications you have recently used? ❑ No ❑ Yes → List medications:

Have you taken aspirin-containing products in the last two weeks? ❑ No ❑ Yes
Have you taken steroid or cortisone-type drugs within the last year? ❑ No ❑ Yes

For Medical Team Use Only:

Allergies

Have you had hives, skin rash, breathing problems, or other allergic reactions to medications? ❑ No ❑ Yes → List medications below:

Name of Medication	Describe Allergic Reaction

Are there medications, other than those you are allergic to, that you would prefer not to take due to prior unpleasant side effects? ❑ No ❑ Yes Please specify below:

Have you had an allergic reaction to:

Iodine or X-ray contrast dye	❑ No ❑ Yes	Latex or Rubber	❑ No ❑ Yes
Bee or wasp stings	❑ No ❑ Yes	Adhesive tape	❑ No ❑ Yes

List any food allergies: ❑ None

For Medical Team Use Only:

Systems Review

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking (√) "No" or "Yes" for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question.

	No	Yes		For Medical Team Use Only:
1. Skin rash, sore, excessive bruising or change of a mole?	❑	❑	Skin	
2. Excessive thirst or urination?	❑	❑	Endo	
3. Change in sexual drive or performance?	❑	❑		
4. Significant headaches, seizures, slurred speech or difficulty moving an arm or leg?	❑	❑	Neuro/EENT	
5. Eye problems such as double or blurred vision, cataracts or glaucoma?	❑	❑		
6. Diminished hearing, dizziness, hoarseness or sinus problems?	❑	❑		
7. Do you wear dentures? If yes: ❑ Full ❑ Upper ❑ Lower ❑ Partial	❑	❑		
8. Bothered with cough, shortness of breath, wheezing or asthma?	❑	❑	Resp	
9. Coughing up sputum or blood?	❑	❑		
10. Exposed to anyone with tuberculosis?	❑	❑		
11. "Blacked out" or lost consciousness?	❑	❑	CV	
12. Chest pain or pressure, rapid or irregular heart beats, or known difficulty with a heart valve?	❑	❑		
13. Awakening at night with shortness of breath?	❑	❑		
14. Abnormal swelling in the legs or feet?	❑	❑		
15. Pain in the calves of your legs when you walk?	❑	❑		
16. Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble?	❑	❑	GI	
17. Significant problems with constipation, diarrhea, blood/changes in bowel movements?	❑	❑		
18. Have you had a colon or rectum x-ray or instrument examination (proctoscopy, sigmoidoscopy, colonoscopy)? Approximate date: Mo: Yr:	❑	❑		
19. Have you had an upper endoscopy to evaluate the stomach for varices? Approximate date: Mo: Yr:	❑	❑		
20. Have you had any treatment for varices? (sclerotherapy, banding)	❑	❑		

Systems Review Continued:	No	Yes	
21. Difficulty starting your urinary stream, completely emptying your bladder or leaking urine from your bladder?	❑	❑	GU
22. Burning or pain when urinating?	❑	❑	
23. Pain, stiffness or swelling in your back, joints or muscles?	❑	❑	Msk
24. Fever within the last month?	❑	❑	Hem/ID/Lymph
25. Enlarged glands (lymph nodes)?	❑	❑	
26. Feel you are at risk for HIV or AIDS?	❑	❑	
27. Immunized for influenza, tetanus/diphtheria and/or pneumonia within the last year?	❑	❑	
28. Experiencing an unusually stressful situation?	❑	❑	General
29. Weight gain or loss of more than 10 pounds during the last 6 months?	❑	❑	
30. Problems falling asleep, staying asleep, sleep apnea or disruptive snoring?	❑	❑	
31. Abnormal nipple discharge or a breast lump?	❑	❑	
32. Have you ever felt a need to cut down on your alcohol consumption?	❑	❑	
33. Do relatives/friends worry or complain about your alcohol consumption?	❑	❑	
34. Have you been physically, sexually, or emotionally abused?	❑	❑	
QUESTIONS 35 – 39 TO BE ANSWERED BY FEMALE PATIENTS ONLY	**No**	**Yes**	Female
35. Have you ever had an abnormal Pap smear? ❑ Unknown	❑	❑	
36. Have you experienced menopause or had a hysterectomy?	❑	❑	
If no: Are you concerned about your menstrual periods?	❑	❑	
Might you be pregnant at this time?	❑	❑	
Date of onset of your last menstrual period: Mo: Day: Yr:			
37. Approximate date of your last Pap smear and pelvic exam: Mo: Yr: ❑ Never			
38. Approximate date of your last mammogram: Mo: Yr: ❑ Never			
39. Number of: Pregnancies: Live Births: Miscarriages/abortions:			

Self-Care/Home Environment Assessment

Do you have difficulty performing these activities by YOURSELF?

Eating	❑ No	❑ Yes
Bathing	❑ No	❑ Yes
Dressing	❑ No	❑ Yes
Walking	❑ No	❑ Yes
Using Toilet	❑ No	❑ Yes
Housekeeping	❑ No	❑ Yes

Do you have any special dietary needs? ❑ No ❑ Yes → Describe:

What is your current living arrangement? ❑ House ❑ Apartment ❑ Nursing Home ❑ Other

Do you live: ❑ Alone ❑ With Spouse/Family ❑ With others → Describe:

List family or friends able to provide assistance with your homecare needs if you would ever require such assistance:

For Medical Team Use Only:

Educational Needs

Are you interested in more information about a specific topic? ❑ No ❑ Yes → ❑ How to stop smoking ❑ Exercise ❑ Stress ❑ Safe sexual practices ❑ Safety (seat belts, smoke detectors, firearms) ❑ Nutrition ❑ Weight control ❑ Violent & abusive behavior ❑ Living wills ❑ Diabetes ❑ Cancer screening ❑ Other _____

For Medical Team Use Only:

Reviewed and Annotated by:

Signature	Pager No.	Date	Signature	Pager No.	Date