NORTH TEXAS HEALTHCARE ASSOCIATES FAMILY MEDICINE
MEDICAL, FAMILY AND PERSONAL HISTORY

NAME: _____ **DATE OF BIRTH:** _____

Reason for today's visit:

_____

_____

Past Medical History: Please circle any conditions which you have had:

LUNG
- Asthma
- Emphysema
- Other _____

EAR-NOSE-THROAT
- Allergic rhinitis
- Frequent ear infections
- Frequent sinus infxns
- Ménière's dz (vertigo)
- Other _____

SKIN
- Eczema
- Psoriasis
- Other _____

ENDOCRINE
- Diabetes mellitus
- Hyperthyroidism
- Hypothyroidism
- Thyroid goiter
- Other _____

CARDIOVASCULAR
- Angina
- Atrial fibrillation
- Blood clots in the lungs
- Blood clots in the veins
- Congestive heart failure
- Heart arrhythmia
- Heart attack
- Heart murmur
- Heart valve disease
- High cholesterol or lipids
- Hypertension
- Other _____

FEMALE or MALE-RELATED
- Abnormal pap smear
- Endometriosis
- Fibrocystic breast disease
- Prostate disease
- Sexual dysfunction
- Other _____

GASTROINTESTINAL
- Bleeding from intestines
- Cirrhosis of the liver
- Colon polyps
- Crohn's disease
- Diverticulitis
- Diverticulosis
- Gallstones
- Hepatitis
- Irritable bowel syndrome
- Pancreatitis
- Stomach ulcers
- Ulcerative colitis
- Other _____

MUSCLE/BONE/JOINT
- Arthritis (non-rheumatoid)
- Fibromyalgia
- Osteoporosis
- Rheumatoid arthritis
- Other _____

INFECTIONS
- HIV will infection
- Serious infection (e.g., pneumonia)
- Sexually transmitted infections
- Other _____

NEUROLOGICAL
- Migraine headaches
- Multiple sclerosis
- Peripheral nerve disease
- Stroke
- Other

MISCELLANEOUS
- Cancer (where?) _____
- Glaucoma
- Kidney stones
- Rheumatic fever
- Systemic lupus erythematosus
- Transfusions

PSYCHIATRIC
- List _____

Explain as needed:

_____

_____

_____

_____

Past Surgical History: Please indicate any surgeries you have had and *WHAT YEAR* you had them:

- _____ Angioplasty
- _____ Appendectomy
- _____ Back or neck surg.
- _____ C-section
- _____ Carotid artery surg.
- _____ Carpal tunnel surg.
- _____ Chest/lung surgery
- _____ Coronary bypass surgery
- _____ Dental surgery
- _____ Ear surgery
- _____ Eye surgery
- _____ Gallbladder
- _____ Hip surgery
- _____ Hysterectomy
- _____ Inguinal hernia
- _____ Knee surgery
- _____ Mastectomy
- _____ Neurosurgery
- _____ Other breast surgery
- _____ Other vascular surgery
- _____ Other (explain): _____
- _____ Prostate surgery
- _____ Sinus surgery
- _____ Stomach surgery
- _____ Thyroid surgery
- _____ Tonsillectomy
- _____ Urinary incontinence surgery

_____

_____

_____

_____

Please list any **ALLERGIES** or **INTOLERANCES** to drugs or other substances, and the reaction you have.

_____

_____

_____

_____

Please list any **MEDICATIONS** you take, their dosage strengths and how many times per day you take them:

_____

_____

_____

_____

NORTH TEXAS HEALTHCARE ASSOCIATES FAMILY MEDICINE

NAME: _____ **DATE OF BIRTH:** _____

FAMILY HISTORY:

Please list the **AGES** of your family and any major **MEDICAL ILLNESSES** they have had.

Mom's age: ____ Illnesses: _____
Dad's age: ____ Illnesses: _____
Sister's(s') age(s): _____ Illnesses: _____
Brother's(s') age(s): _____ Illnesses: _____
Children's birth dates: _____
Children's illnesses: _____

Please **check** which of the following medical conditions have occurred in your family.

☐ Anemia	☐ Epilepsy	☐ High cholesterol	☐ Prostate cancer
☐ Breast cancer	☐ Liver disease	☐ Kidney disease	☐ Stroke
☐ Colon cancer	☐ Heart disease	☐ Neurological disorder	☐ Thyroid disease
☐ Diabetes mellitus	☐ Hemophilia	☐ Osteoporosis	☐ Tuberculosis
☐ Emphysema	☐ High blood pressure	☐ Ovarian cancer	☐ Other _____

_____

PERSONAL INFORMATION

Occupation: _____ **Religious Preference:** _____

Highest level of **schooling**: High school College/Trade school Post-graduate

Marital status: Single Married Divorced Separated Widowed

Do you **smoke**? No Yes (How much? _____)
If you are a former smoker, how long ago did you quit? _____
Do you use smokeless **tobacco**? No Yes (How much? _____)

_____

How often do you drink **alcohol**? Never Rarely 0-3 times per week Nearly every day
When you drink, how many drinks do you have? 1-2 3-5 6 or more
Are you an alcoholic or do you think you may be? Yes No
Have you had a problem with **drugs**/substance abuse? Yes No

Sexual orientation: Not sexually active Heterosexual Homosexual Bisexual
Are you on a special **diet**? _____ How much do you **exercise**? _____
Do you have **pets**? _____

PREVENTIVE MEASURES:

Women Only:

1. When was your last pap smear? _____
2. When was your last breast exam by a doctor? _____
3. *40 years and over:* When was your last mammogram? _____

Women and Men:

1. Have you had a tetanus shot in the past 10 years? If so, when? _____
2. Other vaccinations: _____
3. Have you had your cholesterol checked within the past 5 years? If so, when? _____
4. *50 years and over:*
   Have you ever had a screening test for colon cancer? Yes No Month and Year
   If yes, which one? Colonoscopy / Fecal Occult Blood Test / Other _____ _____