FLEXO

278-0411

Patient/Family Medical History

Patient Name

____
FIRST MIDDLE LAST

Address

____
CITY, STATE, ZIP

Date Form Completed: ____________________

Phone: Home AREA CODE ( ) ____________________

Business AREA CODE ( ) ____________________

Emergency AREA CODE ( ) ____________________

Sex: ☐M ☐F

Birthdate ____________________
Month Day Year

Were you sent here by a physician? Yes______ No______

Physician's name ____________________

Do you want your records sent to him/her? Yes _____ No _____

Physician's address ____________________

Past Medical History: Please check which of the following problems you have had, and if possible, indicate the year.

- ☐ Heart disease ____________
- ☐ Diabetes ____________
- ☐ High blood pressure ____________
- ☐ Cancer (where, kind) ____________
- ☐ Ulcer ____________
- ☐ Lung disease ____________
- ☐ Kidney disease ____________
- ☐ Thyroid disease ____________
- ☐ Blood disorder ____________
- ☐ Anemia ____________
- ☐ Tuberculosis ____________
- ☐ Seizure ____________
- ☐ Allergy ____________
- ☐ Asthma ____________
- ☐ Meningitis ____________
- ☐ Encephalitis ____________
- ☐ Phlebitis ____________
- ☐ Rheumatic heart disease ____________
- ☐ Liver disease (hepatitis, cirrhosis) ____________
- ☐ Other (specify) ____________

Have you ever had:

Blood Transfusions ☐ Yes ☐ No If yes, when? ____________ Was there a reaction? ____________

DRUG ALLERGY ☐ Yes ☐ No If yes, answer:

Name of drug(s)	Date of reaction	Describe reaction

DRUG INTOLERANCE ☐ Yes ☐ No If yes, answer:

Name of drug(s)	Date of reaction	Describe reaction

Steroid Therapy (Cortisone) ☐ Yes ☐ No If yes, when?________

Immunizations: **Rubella (German Measles)** ☐ Yes ☐ No

Whooping Cough ☐ Yes ☐ No

Typhoid ☐ Yes ☐ No

Tetanus ☐ Yes ☐ No **(List year__________)**

Polio ☐ Yes ☐ No

Diptheria ☐ Yes ☐ No

Please list the medications you are currently taking (including birth control pills):

NAME	DOSAGE	WHEN DID YOU START THE MEDICINE?

Menstrual History:

At what age did you start menstruating?____________ Last menstrual period____________

Last pap smear ____________ # of pregnancies ____________ # of miscarriages____________

# of abortions____________ Do you have any menstrual problems?____________

PLEASE TURN OVER AND FILL OUT BACK OF FORM

Please list past **MAJOR HOSPITALIZATIONS** including surgery. Do not list pregnancy unless you had a Cesarean Section or complications.

YEAR	PLACE	ILLNESS/OPERATION	DOCTOR

Please list other past major illnesses/injuries:

YEAR	ILLNESS/INJURY

Patient's Social History:

Occupation ______ Currently employed? ☐Yes ☐No

Education (Highest level completed) ______ Place of Birth ______ Religion ______

Habits: Tobacco ☐Yes ☐No If yes, number of packs per day? ______ How many years? ______

Coffee/Tea ☐Yes ☐No How many cups per day? ______

Alcohol ☐Yes ☐No How much in usual week (drinks or bottles of beer)? ______

Sleep: Approximate number of hours/night ______

Married ☐Yes ☐No Spouse: Age ______ Occupation ______

Family History:

Please list the following information about your family:

	YEAR OF BIRTH	MAJOR ILLNESSES (IF APPLICABLE, CAUSE OF DEATH)	LIVING/ DECEASED	IF DECEASED, WHAT AGE?
Father				
Mother				
Brothers/Sisters				
Children				

Please check (√) which of the following problems your **blood** relatives have had and indicate which relative, e.g., Mother, Father, Grandparents (maternal or paternal)

☐ Heart disease ______

☐ Diabetes ______

☐ High blood pressure ______

☐ Cancer (where, kind) ______

☐ Ulcer ______

☐ Lung disease ______

☐ Kidney disease ______

☐ Thyroid disease ______

☐ Blood disorder ______

☐ Anemia ______

☐ Tuberculosis ______

☐ Seizure ______

☐ Allergy ______

☐ Asthma ______

☐ Liver disease (hepatitis, cirrhosis) ______

☐ Other (specify) ______

This space is to be used for further update

DATE	ADDITIONAL INFORMATION