BUCKEYE FAMILY HEALTH PATIENT HISTORY FORM

Patient's Name: _____

PERSONAL HISTORY

Birthplace _____ Birth Date _____

Nationality _____ Religion _____

Marital Status _____ Health of Spouse _____

Occupations _____

Residence past 5 years: _____

Education through _____ grade Sleep (usual hrs.) _____ Aids to sleep _____

Recreation _____

Exercise _____

Average per day:

Alcohol (type) _____

Tobacco (type) _____

Tea, coffee _____

Medicines taken regularly	Reason	Last Dose

PERSONAL PAST HISTORY

Have you ever had: (Circle 'yes' or 'no')			Year
Measles	yes	no	
Mumps	yes	no	
Whooping Cough	yes	no	
Polio	yes	no	
Scarlet Fever	yes	no	
Diphtheria	yes	no	
Meningitis	yes	no	
Infectious Mono	yes	no	
Tuberculosis	yes	no	
Exposure to TB	yes	no	
Malaria	yes	no	
Hives	yes	no	
Cancer	yes	no	
Venereal Disease	yes	no	
Diabetes	yes	no	
Arthritis	yes	no	
Back Trouble	yes	no	
Bronchitis	yes	no	
Pneumonia	yes	no	
Pleurisy	yes	no	
Asthma	yes	no	
Emphysema	yes	no	
Rheumatic Fever	yes	no	
High Blood Pressure	yes	no	
Heart Disease	yes	no	
Anemia	yes	no	
Bleeding Tendency	yes	no	
Blood Transfusion	yes	no	
Hepatitis	yes	no	
Blood Clots or DVT	yes	no	
Ulcer	yes	no	
Hemorrhoids	yes	no	
Bladder Infections	yes	no	
Kidney Disease	yes	no	
Hay Fever/Sinusitis	yes	no	
Glaucoma	yes	no	
Nose Bleeds	yes	no	

Operations: (Circle 'yes' or 'no')			Year
Tonsils	yes	no	
Appendix	yes	no	
Gall Bladder	yes	no	
Stomach	yes	no	
Breast	yes	no	
Uterus and/or Ovary	yes	no	
Prostate	yes	no	
Hernia	yes	no	
Thyroid	yes	no	
Varicose Veins	yes	no	
Hemorrhoids	yes	no	
Heart	yes	no	
Other	yes	no	

Injuries: (Circle 'yes' or 'no')			
Head	yes	no	
Chest	yes	no	
Abdomen	yes	no	
Broken Bones	yes	no	
Back	yes	no	
Other	yes	no	

Allergies (are you allergic to): (Circle 'yes' or 'no')			
Tetanus Antitoxin	yes	no	
Penicillin	yes	no	
Sulfa	yes	no	
Other Drugs	yes	no	
List:			
Foods	yes	no	
Cosmetics	yes	no	
Other	yes	no	

Immunizations: (Circle 'yes' or 'no')			
Smallpox	yes	no	
Tetanus	yes	no	
Polio Shots / Oral	yes	no	
Pneumonia vaccine	yes	no	
Other	yes	no	

FAMILY HISTORY - Has any blood relative had the following:
(parents, grandparents, siblings, children, aunts, uncles)
Circle 'yes' or 'no' - if so, what relationship:

Anemia	yes	no	
Bleeding Tendency	yes	no	
Leukemia	yes	no	
Repeated Infections	yes	no	
Crippling Infections	yes	no	
Heart Disease	yes	no	
Chronic Lung Disease	yes	no	
Tuberculosis	yes	no	
High Blood Pressure	yes	no	
Kidney Disease	yes	no	
Asthma	yes	no	
Severe Allergies	yes	no	
Mental Illness	yes	no	
Convulsions or Fits	yes	no	
Migraine Headaches	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Obesity	yes	no	
Thyroid Trouble	yes	no	
Peptic Ulcer	yes	no	
Chronic Diarrhea	yes	no	
Cancer	yes	no	

	Present Age, or Age at Death	If living, health (good, fair, poor) if deceased, cause of death
Father		
Mother		
Brothers or Sisters		
1		
2		
3		
4		
5		
6		
Children		
1		
2		
3		
4		
5		
6		

PLEASE DO NOT MAIL THESE FORMS
BRING THEM WHEN YOU COME FOR YOUR APPOINTMENT

Form Continued on Back 

Have you recently (in the past 2 months) had the following: Circle 'yes' or 'no'; if in doubt, leave blank

General

Tire easily, weakness	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
Sensitivity to heat	yes	no
Sensitivity to cold	yes	no

Skin

Eruptions (rash)	yes	no
Change in color	yes	no
Change in hair	yes	no
Change in nails	yes	no

Eyes

Trouble seeing	yes	no
Eye pain	yes	no
Inflamed eyes	yes	no
Double vision	yes	no
Worn glasses	yes	no

Ears

Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge	yes	no

Nose

Loss of smell	yes	no
Frequent colds	yes	no
Obstruction	yes	no
Excess discharge	yes	no
Nosebleeds	yes	no

Mouth

Sore gums	yes	no
Soreness of tongue	yes	no
Dental problems	yes	no

Throat

Postnasal drainage	yes	no
Soreness	yes	no
Hoarseness	yes	no

Breasts

Lumps	yes	no
Discharge	yes	no

Cardio-Respiratory System

Cough, persisting	yes	no
Sputum (phlegm)	yes	no
Bloody sputum	yes	no
Wheezing	yes	no
Chest pain or discomfort	yes	no
Pain on breathing	yes	no
Shortness of breath	yes	no
Difficulty breathing while lying down	yes	no
Swelling of ankles	yes	no
Bluish fingers or lips	yes	no
High blood pressure	yes	no
Palpitations	yes	no
Vein trouble	yes	no

Digestive System

Change in appetite	yes	no
Difficulty swallowing	yes	no
Heartburn	yes	no
Abdominal distress	yes	no
Belching or excess gas	yes	no
Abdominal enlargement	yes	no
Nausea	yes	no
Vomiting	yes	no
Vomiting of blood	yes	no
Rectal bleeding	yes	no
Tarry stools	yes	no
Dark urine	yes	no
Jaundice	yes	no
Constipation	yes	no
Diarrhea	yes	no
Hemorrhoids	yes	no
Need for laxatives	yes	no

Genitourinary System

Increase in frequency of urination (day)	yes	no
Increase in frequency of urination (night)	yes	no
Feel need to urinate without much urine	yes	no
Unable to hold urine	yes	no
Pain or burning	yes	no
Blood in urine	yes	no
Albuminuria	yes	no
Impotence	yes	no
Lack of sex drive	yes	no
Pain with intercourse	yes	no

Endocrine

Thyroid trouble	yes	no
Adrenal trouble	yes	no
Cortisone treatment	yes	no
Diabetes	yes	no

Locomotor

Muscle cramps	yes	no
Muscle weakness	yes	no
Pain in joints	yes	no
Swollen joints	yes	no
Stiffness	yes	no
Deformity of joints	yes	no

Nervous System

Headaches	yes	no
Dizziness	yes	no
Fainting	yes	no
Convulsions or fits	yes	no
Nervousness	yes	no
Sleeplessness	yes	no
Depression	yes	no
Change in sensation	yes	no
Memory loss	yes	no
Poor coordination	yes	no
Weakness or paralysis	yes	no

GYN-OB

Started menstruating at age _____

Date last PAP test _____

Interval between periods _____ days

Duration _____ days

Flow: light normal heavy

Date of last period _____

Pain with periods yes no

Number of pregnancies _____

Number of births _____

Number of miscarriages _____

Weight of babies at birth _____

Date of last test if done previously

Colonoscopy _____

Endoscopy _____

Stress Test _____

Echocardigram _____

Carotid Doppler _____

Aortic Ultrasound _____

Bone Density _____

Mammogram _____

Pap Smear _____

Sleep Study _____

Chest X--ray _____

CT of Chest _____

Dental Cleaning _____

Eye Exam _____

Dermatology Evaluation _____

Influenza Vaccine _____

Pneumococcal Vaccine _____

Tetanus Vaccine _____

Shingles Vaccine _____

_____

Patient's Name

_____

Birth Date

_____

Doctor's Signature

_____

Date