Patient's Name: _____

Birth Date_____

Mother's Name:_____

Father's Name: _____

PERSONAL HISTORY Birthplace _____

Nationality _____ Religion _____

Residence past 5 years: _____

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

Recreation _____

Exercise _____

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	
Valley Fever	yes	no	
Tuberculosis	yes	no	
Exposure to TB	yes	no	
Malaria	yes	no	
Hives	yes	no	
Cancer	yes	no	
Arthritis	yes	no	
Back Trouble	yes	no	
Bronchitis	yes	no	
Pneumonia	yes	no	
Pleurisy	yes	no	
Asthma	yes	no	
Rheumatic Fever	yes	no	
High Blood Pressur	yes	no	
Heart Disease	yes	no	
Anemia	yes	no	
Bleeding Tendency	yes	no	
Blood Transfusion	yes	no	
Hepatitis (yellow jaundice)	yes	no	
Ulcer	yes	no	
Hemorrhoids	yes	no	
Bladder Infections	yes	no	
Kidney Disease	yes	no	
Hay Fever/Sinusitis	yes	no	
Nose Bleeds	yes	no	
Multiple ear infectio	yes	no	

Operations: (Circle 'yes' or 'no')			Year
Ear Tubes	yes	no	
Tonsils	yes	no	
Adenoids	yes	no	
Appendix	yes	no	
Other (please list)	yes	no	

Injuries:		
Head	yes	no
Chest	yes	no
Abdomen	yes	no
Broken Bone	yes	no
Back	yes	no
Other	yes	no

Allergies (are you allergic to):		
Tetanus	yes	no
Penicillin	yes	no
Sulfa	yes	no
Other Drugs	yes	no
List _____		
Nuts	yes	no
Foods	yes	no
Cosmetics	yes	no
Bee Stings	yes	no
Other	yes	no
List _____		

- OVER -

BUCKEYE FAMILY HEALTH

Internal Medicine & Pediatrics

NEW PATIENT HISTORY, ADOLESCENT

Ages 7 - 18

FAMILY HISTORY - Has any blood relative had any of the following: Circle 'yes' or 'no' - if so, what relationship (mother, father sibling or grandparent)

Anemia	yes	no	
Bleeding Tendency	yes	no	
Leukemia	yes	no	
Repeated Infections	yes	no	
Crippling Infections	yes	no	
Heart Disease	yes	no	
Chronic Lung Disea	yes	no	
Tuberculosis	yes	no	
High Blood Pressur	yes	no	
Kidney Disease	yes	no	
Asthma	yes	no	
Severe Allergies	yes	no	
Mental Illness	yes	no	
Convulsions or Fits	yes	no	
Migraine Headache	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Obesity	yes	no	
Thyroid Trouble	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.		
7.		

Immunizations:

Meningitis (Menactra)	yes	no
TDaP (Adacel)	yes	no
HPV (Gardasil)	yes	no
Chicken Pox (Varicella)	yes	no

Do you have a record of childhood immunizations? yes no

Any concerns you would like to have addressed by your physician:

_____

_____

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

Patient Name: _____ **Birth Date:** _____

Have you recently 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 / Irregular heartbeat	yes	no
Vein trouble	yes	no

Digestive System Indicate average food selection each meal:

Breakfast _____

Lunch _____

Dinner _____

Physician's Signature / Date _____

Digestive System (cont'd)

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
Black / 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 with urination	yes	no
Blood in urine	yes	no
Albuminuria / Foamy urine	yes	no
Protein in Urine	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 seizures	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 - for females of menstruating age

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 Duration _____

Number of pregnancies _____

Number of births _____ Number of miscarriages _____

Weight of babies at birth _____