SAN DIMAS FAMILY PRACTICE: MEDICAL HISTORY FORM

Name:		Date of Birth:	Age:	Gender: ☐ M ☐ F
Address:		Email Id:	Marital Status: Single/Married Separated/Divorced/Widowed	
Please check primary phone	Home #: ☐	Work #: ☐	Cell #: ☐	

Do you have a Living Will? ☐ Y ☐ N If Not, do you want information about Advance Healthcare Directives? ☐ Y ☐ N	Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other	Religion: Preferred Language: Referred By:

Preferred PHARMACY Information	**PHARMACY: Secondary/Mail-Order Pharmacy**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Medications – List all medications you take - prescription, vitamins, supplements, herbs, and the dosage	
☐ I do not take any medications	
Medication Name	Dosage

Allergies – List all foods and medications you are allergic to
☐ I do not have any allergies

SOCIAL HISTORY				
Occupation:			Employer:	
How many children do you have? ____ Female(s) ____ Male(s)				
Smoke Detectors in home: ☐Yes ☐No	Firearms in home: ☐Yes ☐No	Seat belt use in your vehicle: ☐Yes ☐No	Carbon Monoxide Detectors in home: ☐Yes ☐No	Radon in home: ☐Yes ☐No

Tobacco Use ☐ No	☐ Daily ___ ☐ Weekly ___ ☐ Less ___ ☐ Former Year Quit: _____	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Vaporizer:

SOCIAL HISTORY		
Alcohol Use ☐ No	☐ Daily ___ ☐ Weekly ___ ☐ Less ___ ☐ Former Year Quit: _____	☐ Beer ☐ Wine ☐ Liquor ☐ Other:
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week: _____	Sleep Pattern: ☐ Changes ☐ No Changes
Recreational Drug Use ☐ No	☐ Daily ___ ☐ Weekly ___ ☐ Less ___ ☐ Former Year Quit: _____	Type:
Caffeine Use ☐ No	☐ Daily ___ ☐ Weekly ___ ☐ Less ___ ☐ Former Year Quit: _____	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:
Sexually Active: ☐ Y ☐ N	Use Protection: ☐ Y ☐ N Form:	

Menstrual History		
Age at 1st Period:	Date of Last Period:	Periods are: ☐ Regular ☐ Irregular
Contraception: ☐ Y ☐ N	# of Pregnancies: # of Miscarriages:	Age at Menopause:
Date of Last Pap Smear:	Pap Smear: ☐ Normal ☐ Abnormal	Hormone Replacement Therapy: ☐ Y ☐ N

MEDICAL HISTORY: Check if you have experienced the following conditions, and year of onset			
Condition	Date	Condition	Date
☐ None		☐ Depression	
☐ Allergies		☐ Diabetes	
☐ Anemia		☐ Gallbladder Disease	
☐ Angina		☐ GERD (Reflux)	
☐ Anxiety		☐ Hepatitis C	
☐ Arthritis		☐ Hyperlipidemia (High Cholesterol)	
☐ Asthma		☐ High Blood Pressure	
☐ Atrial Fibrillation		☐ Liver Disease	
☐ Blood Clots		☐ Migraine Headaches	
☐ Cancer – Type:		☐ Myocardial Infraction	
☐ Cerebrovascular Disease (Stroke)		☐ Osteoporosis	
☐ Coronary Artery Disease		☐ Kidney Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
		☐ Other	

SURGICAL HISTORY: Check if you have received the following procedures, and year performed			
Procedure	Date	Procedure	Date
☐ None		☐ Cholecystectomy (Gall bladder)	
☐ Angioplasty-Stents		☐ Gastric bypass	
☐ Appendix		☐ Hernia Repair	
☐ Arthroscopy Knee/Shoulder		☐ Hip Replacement	
☐ Back Surgery		☐ Knee Replacement	
☐ CABG (heart bypass)		☐ Pacemaker	
☐ Carpal Tunnel Release		☐ Thyroidectomy	
☐ Cataract Extraction		☐ Other	

SURGICAL HISTORY: Check if you have received the following procedures, and year performed			
MALES ONLY		☐ Cesarean Section	
☐ Prostate Biopsy		☐ D &C	
☐ TURP		☐ Hysterectomy Vag/Abd	
☐ Vasectomy		☐ Mastectomy	
☐ Other – List:		☐ Myomectomy	
FEMALES ONLY		☐ Tubal Ligation	
☐ Breast Implant		☐ Other – List:	
☐ Breast Biopsy			

FAMILY HISTORY: Check if any family member(s) has had any of the following conditions							
☐ Adopted							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Allergies/Hay Fever	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease/Dementia	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

HEALTH MAINTENANCE: Check if you have received the following and the date of the most recent exam			
EXAM	Date	EXAM	Date
☐ None		☐ Foot Exam	
☐ Breast Exam		☐ GYN Exam	
☐ Cardiac Stress Test		☐ HPV	
☐ Cholesterol Panel		☐ Influenza Vaccine	
☐ Childhood Vaccines		☐ Mammogram	
☐ Colonoscopy		☐ PAP Test	
☐ DEXA Scan (Bone Density)		☐ Physical Exam	
☐ Echocardiogram		☐ Pneumococcal Vaccine	
☐ EKG		☐ Pulmonary Function Test	
☐ Eye Exam		☐ Tetanus Vaccine	
☐ FOBT (stool card for hidden blood)		☐ Zostavax/Shingles	

Signature: _____ Name: _____ Date: _____