

**Village Family Practice Medical History Form**

PLEASE FULLY COMPLETE THIS FORM: Your answers will help your provider understand your medical concerns and conditions better.

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**ALLERGIES and/or REACTIONS TO MEDICINES:** \_\_\_\_\_

**CURRENT MEDICATIONS:** Prescription, non-prescription medicines, vitamins, and supplements.

Medication	Dose (e.g. Mg/pill)	How many times/day	When started

**PERSONAL MEDICAL HISTORY:** Do you or have you had any of these problems? For yes answers give further details below.

YES/DATE	MEDICAL PROBLEM	YES/DATE	MEDICAL PROBLEM
	Irregular Heart Beat		Kidney Stones
	Congestive heart Failure		Kidney Disease/Infections
	Blood Clot		Breast Disease
	High Cholesterol		Fracture, which bone(s): _____
	High Blood Pressure		Arthritis
	Heart Attack		Gout
	Heart Murmur		Stroke
	Asthma		Dementia
	Skin disease, Type: _____		Cancer, Type: _____
	Pneumonia		HIV
	Pulmonary Embolism		STDs
	Tuberculosis		Blood Transfusion
	Sleep Apnea		Anemia
	Gall Stones		Bleeding Disorder
	Liver Disease/Hepatitis		Seasonal Allergies
	Hemorrhoids		Emphysema/Chronic Bronchitis
	Diabetes Type 1 (Childhood onset)		Stomach Ulcer
	Diabetes Type 2 (Adult onset)		Problems During Pregnancy
	Diverticulitis		Thyroid Disease (High/Low)
	Ulcerative Colitis/ Crohn's		Depression
	Heart Burn/ Reflux		Anxiety

**Further explanation for "yes" answers:** \_\_\_\_\_

**LIST ANY HOSPITALIZATIONS:** (reason and date): \_\_\_\_\_

**WOMEN'S GYNOCOLOGICAL HISTORY:** Sexually active: Yes / No Contraceptive Method: \_\_\_\_\_

Date of First Period: \_\_\_\_\_ Date of last Period: \_\_\_\_\_  
 # of Pregnancies \_\_\_\_\_ # of Deliveries \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_ Menopausal: No / Yes Date \_\_\_\_\_  
 Last PAP smear \_\_\_\_\_ Abnormal PAP smear: Yes / No  
 Last mammogram \_\_\_\_\_ Abnormal mammogram: Yes / No

**HEALTH MAINTENANCE:** When were your most recent screening tests?

Cholesterol Screening? \_\_\_\_\_ Results? \_\_\_\_\_ PSA (Prostate cancer screen)? \_\_\_\_\_ Results? \_\_\_\_\_  
 Sigmoidoscopy? \_\_\_\_\_ Results? \_\_\_\_\_ Stool Test for Blood? \_\_\_\_\_ Results? \_\_\_\_\_

**IMMUNIZATIONS:** Please indicate the date of your most recent: Tetanus \_\_\_\_\_ Pneumovax (Pneumonia) \_\_\_\_\_

**SOCIAL HISTORY:** Tobacco Use: Cigarettes \_\_\_\_\_ Never \_\_\_\_\_ Quit: Date \_\_\_\_\_ Current Smoker: packs/day \_\_\_\_\_ # of years: \_\_\_\_\_

Other Tobacco: Pipe \_\_\_\_\_ Cigar \_\_\_\_\_ Chew \_\_\_\_\_ Interested in quitting? Yes / No  
 Alcohol Use: Do you drink alcohol? No / Yes, # of drinks/ week \_\_\_\_\_ Is alcohol use a concern for you or others? No / Yes  
 Illicit Drug use? No / Yes, Name/s of Drugs \_\_\_\_\_

**SOCIOECONOMICS:** Marital Status: S M D W Other: \_\_\_\_\_ Spouse/Partner's name: \_\_\_\_\_

Children: Names and Ages \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Years of Education/ Highest Degree: \_\_\_\_\_

**SEXUAL ACTIVITY:** Sexually Active: Yes / No / Not Currently Current sex partner(s) is/are: Male \_\_\_\_\_ Female \_\_\_\_\_

**EXERCISE:** Do you exercise regularly? No / Yes, What kind of Exercise? \_\_\_\_\_  
 How long? (minutes) \_\_\_\_\_ How often? \_\_\_\_\_

**SURGICAL HISTORY:** Have you had any of these surgeries? Please use space below for further information if needed.

