Mitchell Family Medicine

Health History

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.

Patient Name:____ DOB: ______/______/______

Medical Conditions

If either you or a family member has or had any of these conditions, check (✓) the box by the condition listed. For family member, indicate their relationship to you (e.g. mother, father, sibling). Please provide a brief description.

Condition	Self	Description	Family Member	Description
Anemia				
Arthritis				
Asthma				
Back Problems				
Blood in Stool				
Cancer				
Change in Bowels				
Chicken Pox				
Dental Problems				
Depression				
Diabetes				
Emphysema				
Hearing Problems				
Heart Problems				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Problems				
Leg Swelling				
Liver Problems				
Lung Problems				
Measles				
Migraines				
Mononucleosis				
Mumps				
Panic Attacks				
Prostate Problems				
Seizures				
Sexually Transmitted Diseases				
Skin Problems				
Stroke				
Thyroid Problems				
Other:				
Other:				

Health History - Page 2 Patient Name:____

WOMEN ONLY	YES	NO	EXPLAIN/DATE
Menstrual Difficulties			
Cystitis			
Mastitis			
Ovarian Cyst			
Breast Cancer			
Other Breast Disease			
Other Gynecological Problems			
Age Periods Started? Age Periods Stopped?			
Date of Last Period? Could you be pregnant now? Y N (circle one)			
Why Periods Stopped?			
Number of Pregnancies? How many resulted in live births? Miscarriage? Abortion?			
Last Pap Smear or female exam? Last Mammogram?			
Method of Birth Control?			
Prior abnormal Pap Smear? Y N If so, Year: Sexually Active? Y N			
History of Human Papilloma Virus? Y N Planning pregnancy in next year? Y N			

MEN ONLY	
Last PSA level check	Sexually Active? Y N
Urine flow problems? Y N	Prostate Problems? Y N
Erection Issues? Y N	Loss of Height? Y N
Lump or Testicle pain? Y N	Lack of energy? Y N

FOR CHILDREN	
Normal Development? Y N	School performance issues? Y N
Normal Growth? Y N	Social or friends concerns? Y N
Normal Language? Y N	Behavioral concerns? Y N

Allergies

Are you allergic or intolerant to any medications? Y N (circle one)

If "Yes", please list and describe your reactions(s)

Do you have food or seasonal allergies? Y N (circle one)

If "Yes", please list and describe your reactions(s)

Medications

Please list all medications you are using including vitamins, herbal supplements and contraception.

Surgeries

Please list any surgeries or procedures (include colonoscopies)you have had with approximate dates.

 Patient Name____

Do you wear artificial devices?	**Yes**	**No**	**(Circle One)**
If 'Yes", please list:			

Please provide the following information:	
Tobacco? Y N Type Packs per day? Date quit?	
Caffeine? Y N # Caffeinated beverages per day? Coffee Tea Soda	
Alcohol? Y N Type: Drinks per week? Date quit?	
Have you ever used illicit drugs? Y N If so, what?	
Seat Belts? Always Occ. Never	Drive at speed limit? Always Occ. Never
Exercise? Y N How many **minutes** Per Day?_____ How many times Per Week?_____	
Foreign travel planned? Y N	

IMMUNIZATIONS	**YES**	**NO**	**DATE**
Pneumonia			
Tetanus			
Hepatitis A			
Hepatitis B			
Measles			
Influenza			
Measles/Mumps			
Other - If yes, what and date?			

Family Members Heath							
	Living Y/N	Age	Good	Fair	Poor	Age at Death	Cause of Death
Children							
Father							
Mother							
Brother(s)							
Sister(s)							

Is there anything of a sensitive nature you would like to discuss with your physician? Y N

____

____

____

Signature of Patient or Patient's Legal Representative

Date

Print Name

Relationship to Patient?

Do you wear artificial devices?	**Yes**	**No**	**(Circle One)**
Please List:			

Family Members Heath							
	Living Y/N	Age	Good	Fair	Poor	Age at Dea	Cause of Death
Children							
Father							
Mother							
Brother(s)							
Sister(s)							