Greater Family Health℠
Care to live greater.

INITIAL MEDICAL HISTORY

NAME: ____________________ **AGE:** ________ **DOB:** ________________ (month/day/year) **TODAY'S DATE:** _______________

PERSON COMPLETING FORM (IF OTHER THAN ABOVE) ____________________ **RELATIOSHIP** ____________________

MEDICATIONS NOW TAKING	DOSE	FREQUENCY	REASON FOR MEDICINE (IF KNOWN)*

***IF MORE SPACE IS NEEDED, USE BACK OF FORM**

ALLERGIES:
____
____

PATIENTS PERSONAL PAST MEDICAL & SURGICAL HISTORY – CHECK IF APPROPIATE

	YEAR		YEAR		YEAR
☐ Alcoholism	______	☐ German Measles	______	☐ Pneumonia	______
☐ Angina	______	☐ Glaucoma	______	☐ Polio	______
☐ Arthritis	______	☐ Gout	______	☐ Psychiatric Problems	______
☐ Asthma	______	☐ Hearth Problems	______	☐ Rheumatic Fever	______
☐ Blood Disease	______	☐ Hemorrhoid	______	☐ Hearth Disease	______
☐ Breast Cancer	______	☐ Hepatitis	______	☐ Rheumatoid Arthritis	______
☐ Fibrocystic Breast Disease	______	☐ Hernias	______	☐ Skin Disease/Cancer	______
☐ Bronchitis	______	☐ High Blood Pressure	______	☐ Sinusitis	______
☐ Cancer/Tumor	______	☐ Liver Disease/Cirrhosis	______	☐ Thyroid Disease	______
☐ Depression	______	☐ Lung Problems	______	☐ Tuberculosis	______
☐ Diabetes	______	☐ Kidney Problems/Stones	______	☐ Ulcers	______
☐ Emphysema	______	☐ Major Trauma	______	☐ Urinary Tract Infections	______
☐ Epilepsy	______	☐ Migraines	______	☐ Venereal Disease	______
☐ Gallstones	______	☐ Pancreatitis	______	☐ Other:	______

HOSPITALIZATION (Besides pregnancies) Medical or Surgical

HOSPITALIZATION	YEAR	OPERATION OR ILLNESS	HOSPITAL	DOCTOR	CITY AND STATE
1st Hospitalization					
2nd Hospitalization					
3rd Hospitalization					

TESTS & IMMUNIZATIONS

	YEAR		YEAR		YEAR
☐ Chet X-Ray	______	☐ Other X-Rays	______	☐ Flu Vaccine	______
☐ Electrocardiogram	______		______	☐ Tetanus	______
☐ Mammogram	______		______	☐ TB Test	______
☐ Cholesterol	______			☐ Pneumovaccine	______

OBSTETRICAL & GYNE PAST HISTORY (IF APPLICABLE)

AGE ONSET OF PERIODS ____________________
AGE OF STOPPING PERIODS ____________________
FREQUENCY OF PERIODS ____________________
DURATION OF PERIODS ____________________
MENSTRUAL PAIN ____________________
LMP ____________________
DATE OF LAST PAP SMEAR ____________________

No. OF TIMES PREGNANT ____________________
No. OF MISCARRIAGES ____________________
No. OF LIVING CHILDREN ____________________
ANY D&C's IN PAST? ________ NO. _______ WHEN ____________
USE OF CONTRACEPTIVE PILL PRESENTLY ____________
EVER IN THE PAST? ☐ YES ☐ NO
FORM OF CONTRACEPTIVE PRESENTLY USED (IF ANY) ________

NAME OF OB-GYNE DOCTOR, IF ANY ____________________

For Staff use only:
Patient Name: ____________________ DOB: ____________ MRN: ____________
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FAMILY HISTORY: Indicate the state of health and medical history for your family member by placing an X in the appropriate box.	Alive	Died	Age	Cause of Death	Allergies	Asthma	Alcoholism	Diabetes	Cancer or Tumor	Epilepsy	Glaucoma	Gout	High Blood Pressure	Kidney or Bladder Trouble	Stomach Duodenal Ulcer	Nervous Breakdown	Rheumatism or Arthrits	Heart Trouble	Migraines	Obesity
FATHER																				
MOTHER																				
BROTHERS																				
SISTERS																				
SPOUSE																				
CHILDREN																				
GRANDPARENTS																				

SOCIAL HISTORY: CHECK APPROPIATE BOX

YOUR OCCUPATION

____

YES	NO	
☐	☐	Do you regularly smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Others _______ For how many years? _____ How many packs? _____
☐	☐	Do you use snuff or chewing tobacco?
☐	☐	Do you usually drink over 4 cups of coffee per day?
☐	☐	Do you drink alcohol? ☐ 1 oz./day ☐ 2 oz./day ☐ 4 oz./day ☐ over 6 oz./day
		Beer: ☐ 1 bottle/day ☐ 2 bottles/day ☐ over 4 bottles/day
☐	☐	Do you or have you used marijuana, cocaine or other similar drugs?
		Which drug___________________________ How often _________________________________ How much ______________________
☐	☐	Do you regularly use "over-the-counter drugs" i.e., aspirin, cold preparations, nasal sprays? Which ones? _________________________
☐	☐	Do you take tranquilizers, i.e. Valium, Lithium, etc.
☐	☐	Do you take sleeping pills?
☐	☐	Are you in an "unsafe" relationship (i.e. is there any physical or metal abuse at home, work or otherwise?)

REVIEW: Check any of the listed symptoms which currently apply to you. Space is provided for listing additional ones.

CONSTITUTIONAL:

- ☐ Weakness
- ☐ Fatigue
- ☐ Weight Loss (When)?____________________
- ☐ Weight Gain (When)?____________________
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Change in Appetite
- ☐ Insomnia
- ☐ Other: ___________________________

EYES:

- ☐ Double Vision
- ☐ Glasses
- ☐ Date Changed: ____________________
- ☐ Loss of Vision ____________________
- ☐ Spots
- ☐ Pain
- ☐ Tears
- ☐ Infections
- ☐ Other: _____________________

NOSE, THROAT, SINUSES:

- ☐ Nosebleeds
- ☐ Sores
- ☐ Bleeding Gums
- ☐ Sore Tongue
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Postnasal Drip
- ☐ Sinusitis
- ☐ Other: __________________

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EAR:
- ☐ Pain
- ☐ Discharge
- ☐ Ringing
- ☐ Deafness
- ☐ Other: ____________________________

SKIN, HAIR:
- ☐ Color Changes
- ☐ Itching
- ☐ Moles
- ☐ Infections
- ☐ Rash
- ☐ Hair Change
- ☐ Other: ____________________________

RESPIRATORY:
- ☐ Cough
- ☐ Sputum
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Pleurisy
- ☐ Asthma
- ☐ Spitting up Blood
- ☐ Seasonal Allergy
- ☐ Bronchitis
- ☐ Other: ____________________________

BREAST:
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Other: ____________________________

CORDIOVASCULAR:
- ☐ Chest Pain
- ☐ Shortness of Breath on Exertion
- ☐ on lying down
- ☐ at night
- ☐ Wheezing
- ☐ How many pillows for sleep?
- ☐ Swelling of Feet
- ☐ Palpitation / Irregular Heart Beat
- ☐ Faintness
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ History of Rheumatic Fever
- ☐ Varicose Veins
- ☐ Calves Hurt When Walking
- ☐ History of Scarlet Fever
- ☐ Other: ____________________________

URINARY TRACT:
- ☐ Frequency
- ☐ Pain
- ☐ Urgency
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Discharge
- ☐ Venereal Disease
- ☐ Other: ____________________________

GASTROINTESTINAL:
- ☐ Appetite Change
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty Swallowing
- ☐ Foods Causing Indigestion or Gas
- ☐ Frequent Indigestion
- ☐ Excessive Gas
- ☐ Vomiting Blood
- ☐ Abdominal Pain
- ☐ Jaundice
- ☐ Use of Milk or Antacid
- ☐ Diarrhea
- ☐ Constipation
- ☐ Recent Change in Bowel Habits
- ☐ Black or Light Stool
- ☐ Use of Laxatives
- ☐ Number of Meals Eaten Per Day ___________
- ☐ Other ____________________________

MUSCULOSKELETAL:
- ☐ Joint Pain or Swelling
- ☐ Bone Pain or Swelling
- ☐ Muscle Pain or Swelling
- ☐ Deformity
- ☐ Muscle Weakness
- ☐ Morning Stiffness
- ☐ Other: ____________________________

ENDOCRINE:
- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Palpitation
- ☐ Change in Voice
- ☐ Too-frequent Urination
- ☐ Excessive Water Drinking
- ☐ Over-Eating
- ☐ Muscle Spasms
- ☐ Abnormal Hair Growth
- ☐ Infertility
- ☐ Other: ____________________________

NEUROLOGIC
- ☐ Convulsions
- ☐ Faintness
- ☐ Involuntary Urinations
- ☐ Stroke
- ☐ Weakness
- ☐ Speech Difficulty
- ☐ Dizziness
- ☐ Tremor
- ☐ Trouble with Gait
- ☐ Changes in Sensations
- ☐ Transient Blind Spells
- ☐ Loss of Coordination
- ☐ Numbness
- ☐ Tingling
- ☐ Headache
- ☐ Other: ____________________________

FEMALE GENITAL SYSTEM:
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Abnormal Bleeding
- ☐ Bleeding After Menopause
- ☐ Menopausal Symptoms
- ☐ Bleeding After Intercourse

MALE GENITAL SYSTEM:
- ☐ Discharge
- ☐ Sore on Penis
- ☐ Pain in Testicle
- ☐ Prostatic Problems

OTHER:
- ☐ Lump in Throat
- ☐ Difficulty in Getting a Deep Breath
- ☐ Nervousness
- ☐ Numbness Around Mouth
- ☐ Little Pains in the Chest
- ☐ Loss of Memory
- ☐ Crying Spells
- ☐ Nightmares
- ☐ Depressions
- ☐ Cannot Sleep
- ☐ Early A. M. Awakening
- ☐ Unusual Fears
- ☐ Unusual Thoughts of Perceptions
- ☐ Hallucinations
- ☐ Problems Due to Impulse Behavior
- ☐ Is there a marriage or Sex Problem? Do you want to discuss it with your doctor? ☐ Yes ☐ No

TRAUMA:
- ☐ Major Trauma
- ☐ Head Trauma
- ☐ Broken Bones
- ☐ Lacerations
- ☐ Other: ____________________________

ADVANCE DIRECTIVES/ LIVING WILL:

Would you like information?

☐ Yes ☐ No

Reviewed by doctor ☐ Yes ☐ No

Date: ____________________________

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