## ***FAMILY PRACTICE - INITIAL OFFICE VISIT***

| DEMOGRAPHICS | | | |
|---|---|---|---|
| Name: | DOB: | Age: | Sex: |
| Address: | City, State: | Zip: | |
| Occupation | Referred by: | | |
| Phone: (W) (H) (Cell) | Pharmacy #: | | |
| Drug Allergies: | | | |

| PAST MEDICAL AND SURGICAL HISTORY | | |
|---|---|---|
| **Hospitalizations/Surgeries** | | |
| **Month/Year** | **Illness or Operation** | **Hospital and Treating MD** |
| | | |
| | | |
| | | |
| | | |
| | | |
| **(continue list on back if necessary)** | | |

| **Current Medications** | | | |
|---|---|---|---|
| **Date Began** | **Medication and Dose** | **Date Began** | **Medication and Dose** |
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

| Relationship | Age If Living | Age At Death | Cause of Death | Health Problems |
|---|---|---|---|---|
| Mother | | | | |
| Grandmother | | | | |
| Grandfather | | | | |
| Father | | | | |
| Grandmother | | | | |
| Grandfather | | | | |
| Sisters | | | | |
| Brothers | | | | |
| Aunts | | | | |
| Uncles | | | | |

## OBSTETRIC AND GYNECOLOGICAL HISTORY

| |
|---|
| Date of: last menstrual period last pap last mammogram |
| Number of: pregnancies births miscarriages/abortions |
| Age of onset of periods frequency length of period |
| History of abnormal pap smear: No Yes Pelvic Pain: No Yes |
| Prolonged or abnormal bleeding: No Yes Abnormal discharge: No Yes |

## SOCIAL HISTORY

| | |
|---|---|
| Smoke? Yes No # packs/day | Alcohol? Yes No # packs/day |
| Recreational drugs? Yes No If yes, explain: | |
| Marital status: Single Married Divorced Separated Widowed | |
| Persons living with you: # of people: Spouse Significant other Pets | |
| Sexually active? Yes No, with Man Woman Both | |

## REVIEW OF SYSTEMS

**Please Circle The Problems You Are Presently Complaining Of:**

| | | | |
|---|---|---|---|
| (1) Headache | (11) Tuberculosis (TB) | (21) Weight Change | (31) Kidney Stones |
| (2) Eye Problems | (12) Chest Pain/Tightness | (22) Hemorrhoids | (32) Frequent Urination |
| (3) Allergies/Hay Fever | (13) Palpitations | (23) Prostate Problem | (33) Trouble Holding Urine |
| (4) Sinus Problems | (14) Heart Disease | (24) Hepatitis | (34) Trouble Shooting Urine |
| (5) Thyroid Disease | (15) Nausea, Vomiting | (25) Diabetes | (35) Bladder Infections |
| (6) Shortness of Breath | (16) Hernia | (26) Cancer | (36) Venereal Diseases |
| (7) Asthma | (17) Indigestion | (27) Arthritis | (37) Skin Diseases |
| (8) Bronchitis | (18) Diarrhea/Constipation | (28) Low Back Pain | (38) Anxiety |
| (9) Pneumonia | (19) Blood In Stools | (29) Swollen Joints | (39) Depression |
| (10) Persistent Cough | (20) Bowel Habit Change | (30) Gout | (40) Other |

## PREVENTION HISTORY

Do you wear seatbelts? Yes No If not, why not?

Do you drink coffee or tea? Yes No If yes, # times/week:

Have you ever engaged in any activity
which has put you at risk of getting AIDS? Yes No If yes, explain:

Do you wish to be tested for HIV? Yes No

### Exercise Profile

Are you currently involved in an exercise program? Yes No Exercise start date:
How many hours per week on average do you:
Perform vigorous aerobic exercise? (i.e., brisk walking, jogging, biking, aerobic classes, etc.)
Perform strength training? (i.e., free weights, weight machines, etc.)
Perform stretching exercises? (i.e., yoga, general stretches)

### Nutrition Profile

What is your current weight?
What is your desirable weight?
What is your current height?