Holy Family Medical Associates, LLC

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Today's Date: ____________________

Name: ____ **Date of Birth:** ____________________

Local Pharmacy: ____
(Name/City/Phone #)

Mail Order Pharmacy: ____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: ____

Timing/Onset: When did symptoms first occur? ____

Duration: Frequency of symptoms? ____

Characterized as/Severity: Describe the severity of the symptoms/pain. ____________________

Associated Signs and Symptoms: Are there any other symptoms associated with your problem? ____________________
____

Modifying Factors: What makes the condition better and/or worse? ____________________

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you had any of the following (currently or in the past)?

___ Abdominal pain
___ Alcoholism
___ Allergies, seasonal
___ Anemia
___ Anxiety
___ Appetite decreased
___ Appetite increase
___ Arthritis
___ Asthma
___ Back pain
___ Bleeds easily
___ Blood in urine
___ Bloody stools
___ Bone fracture
___ Breathing difficulty
___ Bronchitis
___ Bruises easily
___ Cancer
___ Chest pain (currently)
___ Chicken pox
___ Cholesterol elevated
___ Chronic fatigue
___ Colitis
___ Constipation
___ Crohn's disease
___ Depression
___ Diabetes
___ Diarrhea
___ Difficulty sleeping
___ Difficulty swallowing
___ Diverticulosis
___ Dizziness
___ Ear infection
___ Eczema
___ Eye infection
___ Eye problem
___ Fainting
___ Foot pain
___ Gout
___ Headaches, frequent
___ Hearing problem
___ Heart murmur
___ Heart problem
___ Hemorrhoids
___ Hepatitis
___ Hernia
___ Herpes
___ High blood pressure
___ HIV
___ Hives
___ Hoarseness
___ Indigestion
___ Jaundice
___ Joint injury
___ Kidney stones
___ Leg pain
___ Measles
___ Mental illness
___ Moodiness
___ Mumps
___ Muscle weakness
___ Nausea and/or vomiting
___ Nervousness
___ Nose bleeds
___ Numbness and tingling
___ Osteoporosis
___ Pain with urination
___ Palpitation
___ Polio
___ Psoriasis
___ Pulse irregular
___ Rash
___ Rectal bleeding
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Shortness of breath
___ Sinus problem
___ STD
___ Stroke
___ Swelling legs/feet
___ Thyroid disease
___ Tremor
___ Tuberculosis
___ Urethral discharge
___ UTI
___ Varicose veins
___ Vision changes
___ Weight loss
___ Wheezing
___ Other: ____

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

___ ACE Inhibitors ___ Erythromycin ___ Latex ___ Sulfa Drugs
___ Aspirin ___ Iodinated Contrast Dye ___ NSAID's ___ Tetracyclines
___ Codeine ___ Keflex ___ Penicillins

Reaction:____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

PAST SURGICAL HISTORY:

Place an "x" in the box to the left of the surgery/procedure you have had in the past. Then write the year of the surgery/procedure on the line to the right of it.

☐ **None**

☐ Angioplasty____ ☐ Cesarean Delivery____ ☐ Hemorrhoidectomy____ ☐ Neck Surgery____
☐ Appendectomy____ ☐ Cholecystectomy____ ☐ Hernia Repair____ ☐ Sinus Surgery____
☐ Back Surgery____ ☐ Ear Tubes____ ☐ Hip Replacement, Total____ ☐ Thyroidectomy, Total____
☐ Breast Surgery____ ☐ Heart Surgery____ ☐ Hysterectomy____ ☐ Tonsillectomy____

Other: ____

____

SOCIAL HISTORY:

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: ______________________

Do you drink caffeinated beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: ______________________

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: ______________________

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Negative History of:	Mother	Father	Sibling	Child	Mother's Parents	Father's Parents	Other
Alcohol Abuse	☐							
Anemia	☐							
Arthritis	☐							
Asthma	☐							
Bleeding Disorder	☐							
Cancer	☐							
COPD	☐							
Diabetes	☐							
Epilepsy	☐							
Glaucoma	☐							
Heart Disease	☐							
High Blood Pressure	☐							
Mental Illness	☐							
Migraine Headache	☐							
Obesity	☐							
Osteoporosis	☐							
Seasonal Allergies	☐							
Seizure Disorder	☐							
Stroke	☐							
Thyroid Problems	☐							

Other: ______________________________

PREGNANCY / BIRTH HISTORY / MENSTRUAL HISTORY: (New female patients only)

Menstrual flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps

Days of Flow: ______________ Cycle, average length: ______________

First day of last period: ______________

Do you experience pain or bleeding during or after sex? ☐ Yes ☐ No

Contraceptive History: ______________________________

Pregnancy Status: ☐ Pregnant ☐ Positive home pregnancy test ☐ Pregnancy possible

Number of pregnancies (Gravida): ______________ **Number of Deliveries (Para):** ______________

Number of Miscarriages: _____ **Number of Abortions:** _____ **Number of Live Births:** _____

Menopausal: ☐ Yes ☐ No

Date of last PAP Test: ______________ ☐ Normal ☐ Abnormal

Date of last Mammogram: ______________ ☐ Normal ☐ Abnormal