Initial Point
FAMILY MEDICINE

Name:		Reason for today's visit:		
Home phone:	Work Phone:	Male ☐ Female ☐	Race	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Date of Birth:	Current Age:	Religion	Occupation:	
Education				Degree:
Spouse's Name:		Spouse's Occupation:		

PAST MEDICAL HISTORY

SURGERY *(type and year)*			
1.	**2.**	**3.**	**4.**
Other:			

LONGSTANDING MEDICAL PROBLEMS			
1.	**2.**	**3.**	**4.**
Other:			

MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING			
1.	**2.**	**3.**	**4.**
5.	**6.**	**Other:**	

ALLERGIES

Tobacco:	Type	Amt.	Yrs.	Alcohol:	Beer ☐ Wine ☐ Liquor ☐	Have you ever had:	Y/N	Yr.
Never	Cigarettes			Never	Once a week ☐	Pap Smear?		
Quit	Cigar / Pipe			Quit	2-3 times per week ☐	Mammogram?		
	Smokeless			Rarely	Daily ☐	Tetanus immunization		
					Amount:	Pneumovax?		

FAMILY HISTORY

FAMILY MEMBER NAME	LIVING		DECEASED	
	AGE	HEALTH	AGE	CAUSE
Father				
Mother				
Brothers/Sisters				
Spouse				
Children				

HAVE YOU OR A FAMILY MEMBER EXPERIENCED

	YES	NO	WHO
Allergy / Asthma			
Anemia			
Arthritis / Gout			
Birth Defects			
Bleeding Disorder			
Cancer or Tumor			
Diabetes			
Emphysema			
Epilepsy / Convulsions			
Glaucoma			
Heart Trouble			
Hepatitis / Jaundice			
High Cholesterol			
High Blood Pressure			
Kidney or Bladder Trouble			
Mental Illness or Nervous Breakdown			
Migraine Headaches			
Sexually Transmitted Disease			
Stroke			
Thyroid			
Tuberculosis			
Ulcers			
Other			