Greeneville Family Medicine
1404 Tusculum Blvd., Suite 3000
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Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

CURRENT MEDICAL PROBLEM

- Please list and describe the problem for which you came to see the doctor today.

Description of Problem	Date Began

- What concerns you most about this problem or problems ?

_____

_____

PAST MEDICAL HISTORY

- Please List All Medical Problems

Medical Problems	For how long ? (years)

- Please List All Surgeries You Have Had

Type of Surgery / Procedure	Medical Facility / Hospital	Doctor	City

- Please List All Hospitalizations (for reasons other than surgery)

Illness / Problem	Medical Facility / Hospital	Doctor	City

• Are you currently under the care of any other practitioner(s)? NO _____ or YES _____

If Yes, please describe the illnesses or medical problems for which you are being treated:

Illness or Medical Problem	Practitioner or Facility	City

• For Women only:

How many times have you been pregnant? _____

How many times have you given birth? _____

Any miscarriages or abortions? _____

Do you have regular monthly periods? YES ____ or NO _____

• Please List all medications you are now taking that a DOCTOR HAS PRESCRIBED

Name of Medicine (e.g. "hydrochlorothiazide")	Strength (e.g. "25 mg")	How many (e.g. "1")	How Often (e.g. "3 / day")	Approx How Long (e.g. "5 yrs")

• Please list all medications you use such as aspirin, cold tablets, vitamins, herbs, laxatives, antacids, or any medicine bought WITHOUT A PRESCRIPTION

Name of Medicine, Vitamins etc.

_____

_____

ALLERGIES AND SENSITIVITIES

• Please list all medicines you are allergic to and describe how each one affects you

Name of Medicine You Are Allergic to	Reaction

• Please list any food, dust, chemical, soap, pollen, household item, bee sting, etc., that you are allergic to and describe how each one affects you

Name of Substance You Are Allergic to	Reaction

• Are you allergic to eggs or egg products YES _____ or NO _____

FAMILY HEALTH AND HISTORY

• Please give the following information about your immediate family:

	Name	Age if Living	Age at Death	State of Health or cause of Death
Your Mother				
Your Father				
<u>Your Mother's Parents</u>:				
Grandmother				
Grandfather				
<u>Your Father's Parents</u>:				
Grandmother				
Grandfather				

<u>Your Siblings</u> (Brothers and Sisters) -- Please list all, from oldest to youngest in order

	Name	Age if Living	Age at Death	State of Health or cause of Death
Sibling				
Sibling				
Sibling				
Sibling				

<u>Your Children</u> (Please list all, from oldest to youngest in order)

	Name	State of Health
Child		
Child		
Child		
Child		

• Please list any BLOOD RELATIVES that have the following illnesses.

ILLNESS	Family Member (e.g.. "mother", "uncle")	ILLNESS	Family Member (e.g.. "mother", "uncle")
Stroke		Amputation	
Polio		Thyroid Disease	
Epilepsy		Goiter	
Brain Disease		Diabetes	
Nervousness		Gout	
Migraines		Ulcers	
Suicide		Hernia	
Depression		Liver Disease	
Alcoholism		Spastic Colon	
Glaucoma		Gallbladder	
Cataracts		Nervous Stomach	
Blindness		Colitis	
Eye Disease		Kidney Stones	
Hearing Prob.		Kidney Failure	
Ear Disease		Bone Disease	
Allergies		Rheumatoid Arthritis	
Hay Fever		Arthritis	
Asthma		Muscle Disease	
Tuberculosis		Anemia	
Emphysema		Sickle Cell	
Lung Disease		Bleeding Disorder	
High Blood Pressure		Eczema	
Heart Failure		Psoriasis	
Heart Attack		Skin Disease	
		Cancers	

SOCIAL HISTORY AND PERSONAL HABITS

• Please list who lives with you at home

_____

_____

• Please give the name of your spouse (and the date of marriage and/or divorce)

_____

• Please list your occupation: _____ How long? _____

• Church you attend: _____

• Birth Place _____ Family Home _____

• Substance use

Are you currently a smoker? NO _____ or YES_____ Cigarettes, Cigars, Pipe
Have you smoked in the past? NO _____ or YES_____ If so, how long? _____
Do you chew tobacco or dip snuff? NO _____ or YES_____ If so, how long? _____
Do you use alcohol-containing beverages? NO _____ or YES_____
If yes, circle the type -- Beer, Wine, Distilled Liquor
And circle how often -- Daily, Weekly, Monthly, Yearly, Very Rarely

• Education

How far did you go in school? _____
High school you attended: _____ Graduated (Year) _____
If you did not graduate, do you have your G.E.D?. YES _____ or NO _____
Do you have training in a trade? YES _____ or NO _____
If yes, please list: _____

• Do you exercise? YES _____ or NO _____
If yes, how? _____ How often? _____

• What do you do for fun?

_____

• Have you recently had any changes in any of the following? If yes, please explain

Marital status? NO ____ or YES _____ _____
Job or work? NO ____ or YES _____ _____
Residence? NO ____ or YES _____ _____
Financial status? NO ____ or YES _____ _____
Are you having any
legal problems or trouble
with the law? NO ____ or YES _____ _____

• Have you recently felt unsafe or endangered in your home? YES _____ or NO _____
If yes, please explain? _____

HEALTH PRESERVATION

• When was your last complete physical exam? _____
• Have you had a tetanus booster in the last 10 years? YES _____ or NO _____
• For Women only:
When was your last Pap smear: _____
When was your last Mammogram _____
• Do you wear seatbelts while riding or driving in the car? YES _____ or NO _____
• Do you wear a helmet when riding a bike or motorcycle? YES _____ or NO _____

Thank you for completing this questionnaire. Your doctor will review this information carefully. And again, welcome to our practice!