# Greeneville Family Medicine

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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 |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

- Primary Care Physician seen previously? _____ Phone #_____
  Any Specialists? _____ Phone # _____
  _____ Phone # _____
  _____ Phone # _____
  _____ Phone # _____

- 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 medication you are now taking that a DOCTOR HAS PRESCRIBED

| Name of Medicine (e.g.” hydrochlorothiazide”) | Strength (e.g. “25mg”) | How many (e.g. “1”) | How often (e.g.”3/day”) | Approx How long (e.g.”5 years”) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Please list all medication you use such as Aspirin, cold tablets, vitamins, herbs, laxatives, antacids, or any medicine bought WITHOUT A PRESCIPTION
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: | _____ | _____ | _____ | _____ |

Your Siblings (brothers and sisters) – Please list all, from oldest to youngest.

| | Name | Age If Living | Age at Death | State of Health or cause of Death |
|---|---|---|---|---|
| Sibling | _____ | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ | _____ |

Your Children (Please list all, from oldest to youngest)

| | 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 so, how long? _____
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: _____
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? _____
What 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!