PATIENT HISTORY

Cannon Family Practice

TODAY'S DATE ______________________

PATIENT'S NAME ______________________

DATE OF BIRTH ______________________ AGE __________

PLEASE ANSWER EACH QUESTION CAREFULLY

ARE YOU? (circle one): MARRIED SINGLE DIVORCED WIDOW

SPOUSE'S NAME: ______________________________ # CHILDREN: _____

OCCUPATION: ____

REASON FOR THIS OFFICE VISIT: __________________________________

EDUCATION: ____

DATE OF LAST MENSTRUAL PERIOD: _________ / _________ / __________

YOUR MEDICAL HISTORY (circle and give dates if yes)

BLOOD TRANSFUSIONS
HEART DISEASE / MURMUR / HIGH BLOOD PRESSURE / STROKE
EPILEPSY / SEIZURES
MIGRAINE HEADACHES
ANXIETY / DEPRESSION / EMOTIONAL ILLNESS
BIPOLAR DISORDER
LUNG DISEASE (TB / ASTHMA)
PHLEBITIS / BLOOD CLOTS / PULMONARY EMBOLISM
VARICOSE VEINS
KIDNEY DISEASE / THYROID DISEASE / DIABETES
HEPATITIS / LIVER DISEASE / GALLBLADDER DISEASE
EATING DISORDER (ANOREXIA OR BULIMIA)
RAPID WEIGHT CHANGES UP OR DOWN
ANEMIA / BLOOD DISORDER
EASY BRUISING / BLEEDING OR CLOTTING PROBLEMS
CANCER
COLLAGEN VASCULAR DISEASE (SUCH AS LUPUS)
ARTHRITIS / BACK PROBLEMS / BONE FRACTURES
URINARY / BOWEL PROBLEMS / COLITIS
SEXUAL PROBLEMS
EVER TAKEN: HEPARIN / STEROIDS / THYROID MEDICATION
EVER HAD CHOLESTEROL (LIPID) TEST
EVER HAD A COLONOSCOPY (SCOPE IN RECTUM)
IMMUNIZED AGAINST HEPATITIS B

LIST SURGERIES OR OTHER HOSPITALIZATIONS FOR ILLNESS:

____
____
____
____

GYNECOLOGICAL HISTORY (FEMALES ONLY)

AGE WHEN PERIODS BEGAN: ____________________________________
CURRENT BIRTH CONTROL METHOD: _____________________________
EVER USED: IUD OR BIRTH CONTROL PILLS (circle if yes)
DATE (YEAR) OF LAST PAP SMEAR: ______________________________
DATE (YEAR) OF LAST MAMMOGRAM: _____________________________

YOUR PERSONAL HISTORY

ALLERGIES TO MEDICATIONS: ____________________________________
____
____

OTHER ALLERGIES: ____
____
____

CURRENT MEDICATIONS: ____
____
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____
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____

DO YOU SMOKE? _______ NUMBER OF CIGARETTES PER DAY? _______
ALCOHOL USE: ____
EXERCISE TYPE: __________________________ HOW OFTEN? _________

FAMILY HISTORY - DISEASE IN PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN, AUNTS, UNCLES AND COUSINS (circle if yes and write down which family member)

BREAST CANCER / OVARIAN CANCER
UTERINE CANCER / COLON CANCER
PROSTATE CANCER
DIABETES / HIGH BLOOD PRESSURE
HEART DISEASE / HEART ATTACK / HIGH CHOLESTEROL
OSTEOPOROSIS (THIN BONES) / DOWAGER'S HUMP
PREMATURE MENOPAUSE
ALZHEIMER'S DISEASE
STROKE
BLEEDING OR BLOOD CLOTTING PROBLEMS
OTHER: ____
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PATIENT'S SIGNATURE