MIDDLETOWN VALLEY FAMILY MEDICINE

Health History Intake Form

Today's Date: ___________________________

Patient Name: ____

Date of Birth: ______________________**Age:** _____

Previous Primary Care Physician (If Any):____

Phone: ___________________________**Address:**______________________________________

Other physicians involved in your care: ____

____

Allergies: (medication, food; please indicate reaction if any) ______ none

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

Medication List: (Please list name/dose/frequency; include vitamins and herbs)

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ ________________________________

Family History: (please indicate deceased or alive, medical issues, and age)

Relative	Age	Living/Deceased	Cause of Death	Medical History
Father	____	L/D		
Mother	____	L/D		
Siblings __________ __________ __________	____ ____ ____	L/D L/D L/D	__________ __________ __________	__________ __________ __________
Maternal Grandmother	____	L/D		
Maternal Grandfather	____	L/D		
Paternal Grandmother	____	L/D		
Paternal Grandfather	____	L/D		
Children _____ _____ _____	____ ____ ____	L/D L/D L/D	__________ __________ __________	__________ __________ __________

Has a family member had a heart attack or stroke prior to age 50? **Y/N**

Habits:

Alcohol: □ none □ Yes: Drinks per day ______ frequency/week______ what kind____________

Tobacco: □ none □ Yes: Chew or smoke _______How many/day______ Since______________

Caffeine: □ none □ Yes: What Kind___________ How many/day_________________________

Other Recreational Drugs: □ none □Yes: What Kind_____________ How many/day_________

Do you drive? □ Yes □No Do you always wear a seatbelt? □Yes □No

Do you exercise? □ Yes □ No If yes, how much? __________________________________

Social History:

Work: □ Employed □ Unemployed □Retired □Disabled

Current Occupation: ____

Marital Status: □ Married □Single □Divorced □Domestic Partner □Widowed

Sexual Preference: □ Men □Women □Both □Refused

Children (ages):____

Hobbies: ____

Sports: ____

Pets: ____

Other: ____

Past Surgical History (Please indicate Date and Doctor)

□None

□Cataracts___________________________

□Lasik ______________________________

□Tonsillectomy_______________________

□Thyroidectomy______________________

□Adenoidectomy______________________

□Coronary Bypass____________________

□Cardiac Stents________________________

□Pacemaker___________________________

□Heart Valve__________________________

□Gall Bladder_________________________

□Appendectomy________________________

□Bowel/Stomach Resection______________

□Bariatric Surgery_______________________

□Hysterectomy__________________________

□Endoscopy_____________________________

□Colonoscopy___________________________

□Hernia________________________________

□Spinal Surgery_________________________

□Tubal Ligation_________________________

□Bladder Surgery________________________

□Prostate Surgery/resection________________

□C-Section______________________________

□Orthopedic/Joints_______________________

□ Hemorrhoidectomy______________________

□OTHER____
____
____
____

Preventive Care: When was your last:

Tetanus Booster ________Flu Shot_______ Pneumonia Vaccine ______Hepatitis Vaccine_______

Flexible Sigmoidoscopy/Colonoscopy________________ Bone Density_______________________

Dental Exam_____________________ Eye Exam___________________________

FEMALE ONLY: Self breast exams? **Y/N** Do you see an OB/GYN? **Y/N** Who_________________

Last Mammogram? ___________Last PAP Smear_________ Last menstrual period_____________

MALE ONLY: Self testicular exam? **Y/N** Erectile Dysfunction? **Y/N**

Last Prostate blood test (PSA) ______________ Last Prostate/Rectal Exam? ______________

Past Medical History: (Please check Yes or No. If yes, Please indicate Date and Treating Physician)

Medical Hx	Yes	No	Date	TREATING PHYSICIAN
Headaches				
Stroke				
Seizures				
Pneumonia				
Diabetes (Type 1 or Type 2)				
Thyroid Disease				
Glaucoma				
Macular Degeneration				
Hearing Loss				
High Blood Pressure				
Blood Clots □Pulmonary (Lung Clots)				
□DVT (Leg Clots)				
Heart Burn, Reflux				
Stomach Ulcers				
Heart Disease				
□Coronary Disease				
□MI/Heart Attacks				
□Congestive Heart Failure				
□Atrial Fibrillation				
□Angina				
□Valve Disorder				
High Cholesterol				
Gastrointestinal Bleeding				
Hepatitis (A,B,C)				
HIV/AIDS				
Chronic Wounds				
Cancer (Type)				
Urinary Tract Infections				
Incontinence				
Kidney Stones				
COPD (Emphysema, Bronchitis)				
Asthma				
Depression				
Bipolar Disorder				
Anxiety				
Fibromyalgia				
Chronic Fatigue Syndrome				
Arthritis				
Gout				
Osteoporosis				
Prostate Disease				
Breast Disease				
Erectile Dysfunction				

Other: ____

Please check any that apply to you: _____no problems

General
- Fever
- Sweats

Mental Health
- Insomnia
- Guilt
- Depression
- Anxiety
- Suicidal thoughts

Neurological System
- Numbness
- Tingling
- Headaches
- Weakness

Endocrine System
- Excessive urination
- Excessive thirst
- Fatigue
- Heat intolerance
- Cold intolerance

Respiratory
- Cough
- Shortness of breath
- Wheezing
- Shortness of breath with exertion

Skin
- Rash
- Changing mole
- Itching
- Slow healing wounds

Allergy
- Seasonal allergies
- Sneezing
- Runny Nose
- Nasal congestion
- Post nasal drip

GI System
- Nausea
- Vomiting
- Constipation
- Abdominal pain
- Diarrhea
- Blood in stool

Ears/Nose/Throat
- Ear pain
- Runny nose
- Sneezing
- Post nasal drip
- Swelling

Cardiovascular
- Chest pain/pressure
- Ankle swelling
- Palpitations

Nutrition
- Special diet
- Weight gain/loss

Eyes
- Changing vision
- Blurred vision

Genitourinary
- Urinary frequency
- Burning with urination
- Blood in urine
- Problems urinating
- Awaken at night to urinate
- Problems with sex
- Exposure to sexually transmitted disease

Musculoskeletal
- Joint swelling
- Joint pains
- Muscle pains

Hematologic System
- Easy bruising
- Easy bleeding
- Hard to stop bleeding

Middletown Valley Family Medicine

Family Medical History Form

Please complete the form below to the best of your knowledge. Indicate which family members have the following medical conditions by placing a check in the open boxes.

Patient Name: ________________________ D.O.B: ____________ Date: ____________

Medical Condition	Father	Mother	Brother (Full)	Sister (Full)	Son	Daughter
Alzheimer's						
Alcoholism						
Asthma						
Bleeding Disorder						
Cancer (Specify Type)						
Cirrhosis						
Depression						
Diabetes Type 1						
Diabetes Type 2						
Heart Disease (i.e. heart attack, bypass surgery, stent placement, sudden death)						
Hepatitis (Specify Type)						
Hyperlipidemia (i.e. High Cholesterol)						
Hypertension (i.e. High Blood Pressure)						
Inflammatory Bowel Disease (i.e. Crohn's or Ulcerative Colitis)						
Kidney Disease						
Lupus						
Mental Illness						
Migraine						
Multiple Sclerosis						
Osteoporosis						
Psoriasis						
Rheumatoid Arthritis						
Seizures						
Stroke (CVA)						
Thyroid Disease						
Other						