FAMILY PRACTICE - INITIAL OFFICE VISIT

DEMOGRAPHICS			
Name:	DOB:	Age:	Sex:
Address:	City, State:	Zip:	
Occupation	Referred by:		
Phone: (W) (H) (Cell)	Pharmacy #:		
Drug Allergies:	Race: (for kidney Calculation)		

PAST MEDICAL AND SURGICAL HISTORY		
Hospitalizations/Surgeries		
Month/Year	**Illness or Operation**	**Hospital and Treating MD**

(continue list on back if necessary)

Current Medications

Date Began	Medication and Dose	Date Began	Medication and Dose

FAMILY HISTORY

Relationship	Age If Living	Age At Death	Cause of Death	Health Problems
Mother				
Grandmother				
Grandfather				
Father				
Grandmother				
Grandfather				
Sisters				
Brothers				
Aunts				
Uncles				

OBSTETRIC AND GYNECOLOGICAL HISTORY
Date of: last menstrual period last pap last mammogram
Number of: pregnancies births miscarriages/abortions
Age of onset of periods frequency length of period
History of abnormal pap smear: No Yes Pelvic Pain: No Yes
Prolonged or abnormal bleeding: No Yes Abnormal discharge: No Yes

SOCIAL HISTORY	
Smoke? Yes No # packs/day	Alcohol? Yes No # drinks/day
Recreational drugs? Yes No If yes, explain:	
Marital status: Single Married Divorced Separated Widowed	
Persons living with you: # of people: Spouse Significant other Pets	
Sexually active? Yes No, with Man Woman Both	

REVIEW OF SYSTEMS			
Please Circle The Problems You Are Presently Complaining Of:			
(1) Headache	(11) Tuberculosis (TB)	(21) Weight Change	(31) Kidney Stones
(2) Eye Problems	(12) Chest Pain/Tightness	(22) Hemorrhoids	(32) Frequent Urination
(3) Allergies/Hay Fever	(13) Palpitations	(23) Prostate Problem	(33) Trouble Holding Urine
(4) Sinus Problems	(14) Heart Disease	(24) Hepatitis	(34) Trouble Shooting Urine
(5) Thyroid Disease	(15) Nausea, Vomiting	(25) Diabetes	(35) Bladder Infections
(6) Shortness of Breath	(16) Hernia	(26) Cancer	(36) Venereal Diseases
(7) Asthma	(17) Indigestion	(27) Arthritis	(37) Skin Diseases
(8) Bronchitis	(18) Diarrhea/Constipation	(28) Low Back Pain	(38) Anxiety
(9) Pneumonia	(19) Blood In Stools	(29) Swollen Joints	(39) Depression
(10) Persistent Cough	(20) Bowel Habit Change	(30) Gout	(40) Other

PREVENTION HISTORY
Do you wear seatbelts? Yes No If not, why not?
Do you drink coffee or tea? Yes No If yes, # times/week:
Have you ever engaged in any activity which has put you at risk of getting AIDS? Yes No If yes, explain:
Do you wish to be tested for HIV? Yes No
Exercise Profile
Are you currently involved in an exercise program? Yes No Exercise start date: How many hours per week on average do you: Perform vigorous aerobic exercise? (i.e., brisk walking, jogging, biking, aerobic classes, etc.) Perform strength training? (i.e., free weights, weight machines, etc.) Perform stretching exercises? (i.e., yoga, general stretches)
Nutrition Profile
What is your current weight? What is your desirable weight? What is your current height?