Family Medicine of Stark County

6512 Whipple Avenue NW
North Canton, OH 44720

Name: **Age:** **Date:** **Occupation:**

Family History

	Age	Allergy	Alcohol abuse	Arthritis	Bleeding disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Disease	Blood Pressure	Psychiatric	Stroke	Tuberculosis	Other	Cause of Death
Mother's Mother																
Mother's Father																
Father's Mother																
Father's Father																
Mother																
Father																
Brothers																
Sisters																
Spouse																
Children																

Hospitalization, Operations, and Injuries

List Cause or Type, Include psyciatric care. Please Omit Pregnancies.	Year
1	
2	
3	
4	
5	
6	
7	

Serious Illness: list current or past illnesses not mentioned above.

1
2
3
4
5

Medications: List all currently used medications and supplements, including all non prescription drugs

Allergies: Please list all known allergies, especially to medications.

Tests: Please give year of most recent test or immunization.

Chest X-Ray	EKG	PAP/Prostate Exam	Tetanus
Tuberculosis	Other X-Ray	Mammogram	

Habbits:	Yes	No	If yes, Please Describe (Amount and Frequency)
Smoking			
Alcohol			
Coffee Tea			
Other Drugs			
Exercise			

Please check any item which applies to you currently or in the past

Weight gain or loss		Heart disease, murmur		Tremor	
Unusual fatigue		Chest pain		Passing out	
Sleep problems		Racing, pounding heart		Speech problems	
Disabled		Shortness of breath		Weakness or paralysis	
Hepatitis		Lung or breathing prob		Coordination problems	
Rheumatic fever		Cough		Memory problems	
Tuberculosis		Pneumonia		Thinking problems	
Venereal Disease		More frequent urination		Bowel control problems	
Asthma		Pain or blood with urine			
Eczema		Leaking urine		**MALES ONLY**	
Hay Fever		Urinating at night		Change in urine stream	
Hives		Kidney or bladder infection		Prostate trouble	
Diabetes		Kidney stones		Lumps on testicles	
Cholesterol/triglycerides		Recurrent adcominal pain		Sex concerns	
Thyroid trouble		Ulcers			
Anemia		Vomited blood		**FEMALES ONLY**	
Bleeding or bruising		Bloody or black stool		Menstrual trouble	
Growing moles/lumps		Heartburn		Vaginal discharge	
Other skin problems		Gallbladder disease		Abnormal bleeding	
Do you wear glasses		Change in appetite		Tubal infections	
Glaucoma		Swallowing problems		Problems getting pregnar	
Other eye problems		Hernia		Breast lumps or pain	
Hearing difficulties		Hemorrhoids		Sex concerns	
Ringing in ears		Polyps		Age period began	
Dizziness		Arthristis or Gout		Number of pregnancies	
Sinus infections		Bursitis		Miscarriages or abortions	
Motion sickness		Fractured bones		Caesarean section	
Dental problems		Back Trouble		Type of birth control	
Last Dental Visit		Headaches			
High Blood Pressure		Seizures			

Pediatric: Complete the section for children under 12 years old

Birth Weight ________________ lbs. ______________ oz.

Was child born early? ________________ Was child born late? ________________ How many weeks? ______________

Describe any Complications in the following:

Pregnancy ____

____

____

Labor and Delivery ____

____

____

How many days after delivery did child stay in hospital? ______________________ days

Immunizations: Give dates of all shots **OR** date child had disease

DPT ____

Polio ____

Measles ____________________ Mumps ____________________ Rubella ____________________

Hepatitis B ____________________ Varicella ____________________ Chicken Pox ____________________

Please check all items below that apply to child now or in the past:

Recurrent vomiting		Problems in school		Problems with self contro	
Chronic diarrhea		Bed wetting (over age 5)		Other Problems:	

List other problems you wish to discuss with your doctor: