Name________________________________ Date ________________

Date of Birth ____

Religion ________________________ Education Level ________________

Lone Star Family Health Center

704 Old Montgomery Rd
Conroe, Texas 77301

Have you, your spouse, or a “blood” relative ever had the following	Yourself Yes	Yourself No	Relative Yes	Relative No	Relationship or Details	Doctor’s Notes
Diabetes	☐	☐	☐	☐		
Thyroid problems	☐	☐	☐	☐		
Dizziness or fainting	☐	☐	☐	☐		
Heart Trouble or chest pain	☐	☐	☐	☐		
High blood pressure	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐		
Hay fever or allergies	☐	☐	☐	☐		
Pneumonia	☐	☐	☐	☐		
Bowel / GI disorder	☐	☐	☐	☐		
Stomach ulcers	☐	☐	☐	☐		
Bleeding or blood disorder / Anemia	☐	☐	☐	☐		
Cancer	☐	☐	☐	☐		
Blindness or Glaucoma	☐	☐	☐	☐		
Deafness	☐	☐	☐	☐		
Neurologic disease(including Seizures)	☐	☐	☐	☐		
Stroke	☐	☐	☐	☐		
Depression	☐	☐	☐	☐		
Nervousnes	☐	☐	☐	☐		
Mental retardation	☐	☐	☐	☐		
Arthritis or bone Disorder	☐	☐	Hospitalizations/ Surgery		Year	
Sexual disorder	☐	☐				
Venereal Ddisease	☐	☐				
Chicken pox	☐	☐				
Hepatitis or jaundice	☐	☐				
Injuries other than strains or sprains	☐	☐				
Major or prolonged illness	☐	☐				
Blood transfusion	☐	☐				

Do you smoke or use oral tobacco?
Yes ☐ How long? __________
No ☐ Amount ____________
If quit, how long?____________

Do you have a history of substance abuse?
Yes ☐ No ☐

Current Medications:
(Please list all)
____
____
____
____
____
____
____
____

Do you drink Alcohol?_________
Type _______Amount _________

Coffee / other caffeine?
Amount ___________

Do you consider your lifestyle health-conscious?
(exercise,salt, fat intake, etc.) ____

Drug allergies

____
____
____
____
____

FOR WOMEN ONLY:

Age periods began ____________________
How long do they last __________________
How many days apart are they ___________
Menstrual problems ___________________

Number of pregnancies _________
Number of miscarriages ________
Number of children ____________
Planning children? _____________