Wattles Park Family Practice

Adult History

Name:____________________________ DOB:______________ Date: _________________________

Disease History

Please check any that you have or have had

Eye/Ear/Nose
_ Eye Pain
_ Double Vision
_ Glaucoma
_ Hearing Loss
_ Ringing in ears
_ None
_ Other_________

Heart
_ High Blood Pressure
_ Heart Attack
_ Heart Murmur
_ Chest Pain
_ Shortness of breath
_ Chest discomfort with exercise
_Heart disease
_ None
_ Other_________

Kidney/Bladder
_ Urinate frequently
_ Urinary pain or itching
_ Urinary infection
_ Leakage
_Kidney stones
_ Bloody urine
_ None
_Other___________

Lungs
_ Bronchitis
_ Emphysema
_ Sinusitis
_ Phlegm when coughing
_ Asthma
_ Tuberculosis (TB)
_ Chronic cough
_ None
_ Other____________

Skin
_ Acne
_ Dermatitis
_ Psoriasis
_ Bruise easily
_ None
_ Other__________

Muscular/Skeletal
_ Muscle weakness
_ Back/Neck injury
_ Backaches
_ Broken Bones
_ None
_Other_________

Nervous System
_ Headache
_ Fainting or dizzy spells
_ Epilepsy
_ Head injury
_ Nerve injury
_ None
_ Other_________

Systemic
_ Diabetes (Sugar)
_ Glandular trouble
_ Thyroid
_ Unusual lumps
_ Nipple discharge
_ Stomach/bowel problems
_ Hepatitis
_Yellow Jaundice
_ Alcoholism
_ Night Sweats
_ AIDS
_ None
_ Other_________

Teeth/Mouth
_ Mouth sores
_ Loose teeth
_ Dentures
_ None
_ Other___________

Vascular
_ Circulation problem
_ Anemia
_ Sickle cell
_ Bleeding tendencies (bleeding easily)
_ Nose bleeds
_ Calf pain
_ Ankle swelling
_ None
_ Other_____________

List any surgeries please include the year:____
____

List any allergic reactions or sensitivities to medication(s)____

List any medications you are currently taking____
____

Have you ever had any of the following illnesses:

_ Chickenpox _ Smallpox _German Measles _Hard Measles _ Diphtheria
_ Mumps _ Scarlet Fever _ Strep Throat

Women

Have you had the following problems:

_ Breast lumps _ Discharge from nipples _ Vaginal discharge
_ Uterine infections _ Bleeding between periods _ Abnormal Pap Smears

Age of first period ___________
Average number of days for flow ___________
Length of time between period ___________
Number of pregnancies ___________
Number of live births ___________
Number of miscarriages ___________
Number of abortions ___________

Number of living children ___________
Are you pregnant now? ___________
Date of last pap smear ___________
Date of last mammogram ___________
Have you ever had an abnormal pap smear? ___________
Have you ever had an abnormal mammogram? _________
Do you regularly preform self-breast exams? ______

Men

Have you had any of the following problems:

_ Frequency in urination _ Testicular pain or swelling _ Prostate trouble _Impotence
Do you regularly perform testicular exams? _________

Please check all that apply	Father	Mother	Father's Parents	Mother's Parents	Siblings Children
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy					
Bleeding Disorder					
Kidney Disease					
Thyroid Disease					
Mental illness					
Parkinson's Disease					
Alzheimer's Disease					
Huntington's Disease					
Other					

Social History

Do you smoke? Y N
Cigars? Y N
Cigarettes? Y N
How much? _________
Do you drink? Y N
Liquor? Y N
Beer? Y N
How much? _________
Do you use illegal drugs? Y N
What kind?_________________
How much? _________
Do you use chewing tobacco? Y N
How much? __________
Have you ever been treated for alcohol/substance abuse? Y N
How long ago? _________
Do you see any other doctors? If yes, list doctors' name:_________________
Do you drink caffeinated beverages? Y N
Do you exercise? Y N

Signature:________________________________ Date:________________

Reviewer's Signature:________________________ Date:________________