Patient Health History Form

SIMON Family Medicine
YOUR FAMILY'S DOCTOR

Name:	Date of Birth:	Today's Date:

Reason for Visit:

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Living/Deceased (circle)	L D	L D	L D	L D	L D	L D
What age?						
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

Social History

☐Married ☐Single ☐Divorced Occupation:_____

☐ Smoking Packs/Day: _____ ☐ Coffee:_____cups/day

Yrs. Quit: _____ ☐Soda: _____cups/day

Yrs. Stopped: _____ ☐Alcohol: _____drinks/wk

☐ Exercise routine: _____ **Diet:** Salt intake: High Med. Low

_____ Fat intake: High Med. Low

☐Contact with blood or body fluid at work: _____

Sleep:

☐ Difficult falling asleep ☐ Continuity disturbance

☐ Snoring ☐ Early morning awakening

☐Daytime drowsiness

Drug Allergies:

Current Medications:

HOSPITALIZATIONS OR SURGERIES

Reason	Date		Reason	Date

MEDICAL HISTORY

◯ Headache	◯ Lactose intolerance	◯ Depression
◯ Shortness of breath	◯ Gallbladder disease	◯ Gout
◯ Heart Palpitations	◯ Prostate disease	◯ Stroke
◯ Heart Murmur	◯ Bowel irregularity	◯ Cancer
◯ Chest Pain	◯ Incontinence	◯ Rheumatic Fever
◯ Dizziness/fainting	◯ Sexual/menstrual dysfunction	◯ Glaucoma
◯ Peripheral Vascular Disease	◯ Venereal Disease	◯ Epilepsy/Convulsions
◯ Allergies/ hay fever	◯ Diabetes	◯ Bleeding Disorder
◯ Asthma/ emphysema	◯ Hepatitis	◯ Kidney Disease
◯ Bronchitis	◯ Anemia	◯ Thyroid Disease
◯ Pneumonia	◯ Arthritis	◯ Mental Illness
◯ Ulcer	◯ Osteoporosis	◯ Other: (Please specify):
◯ GI Disorder	◯ Hypertension (High Blood Pressure)	_____