Patient Health History Form

SIMON Family Medicine
YOUR FAMILY'S DOCTOR

Patient Name:	Date of Birth:	Today's Date:

Reason for Visit:

Patient's Family History

Father: Living Deceased Age:

Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood Pressure	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Mother: Living Deceased Age:

Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood Pressure	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Paternal Grandfather: Living Deceased Age:

Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Paternal Grandmother: Living Deceased Age:

Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Social History

☐Married ☐Single ☐Divorced

Smoking: Have you ever smoked? ☐Yes ☐No

☐Current Every Day: # packs/day:____ #Yrs: _____

☐Past Smoker: #packs/day_____ __

How long did you smoke?_____

Last date smoked_____

Alcohol: History of alcohol use? ☐Yes ☐No

☐Beer____ ____cans/week

☐Wine____ ____glass/week

☐Hard Liquor____ ____glass/week

Have you ever used any illegal or street drugs? ☐Y ☐N

If yes, how long were you sober? _____

Drug Allergies (please list symptoms of allergy)

Do you have any drug allergies? Yes No

If yes, please describe below:

Hospitalizations or Surgeries

Have you ever been hospitalized? Yes No

If yes, please describe below:

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Maternal Grandfather: Living Deceased Age:
Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Maternal Grandmother: Living Deceased Age:
Medical Conditions:

Heart Disease	Glaucoma	Bleeding Disorder
High Blood	Diabetes	Kidney Disease
Stroke	Epilepsy/Convulsions	Thyroid
Mental Illness	Osteoporosis	Cancer

Other:

Other Significant Family History:

By signing below, I have read and acknowledge the following statement:

Full disclosure of any health issues and current medications is vital to forging and maintaining a good relationship with Simon Family Medicine. We maintain the right to dismiss patients who fail to complete this form completely and honestly.

_____
Name (Printed)

_____
Signature

_____
Date

Current Medications:

Name of Medication	Dosage		Name of Medication	Dosage

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)	_____