Current Symptoms

Name: ______________________________ Birth Date: ____________ Today's Date: ____________

Please indicate if you have had any of the following symptoms **recently (over the last week or two)** and explain if necessary.

1. Severe or unusual headaches YES NO ________________________
2. Hearing problems YES NO ________________________
3. Vision problems (other than nearsightedness or farsightedness) YES NO ________________________
4. Sinus problems or hay fever YES NO ________________________
5. Hoarseness YES NO ________________________
6. Problems with teeth or gums YES NO ________________________
7. Severe skin problems YES NO ________________________
8. Weight loss or gain YES NO ________________________
9. Chest pains or discomfort YES NO ________________________
10. Shortness of breath YES NO ________________________
11. Cough or phlegm YES NO ________________________
12. Stomach problems (pain, nausea, vomiting) YES NO ________________________
13. Diarrhea or constipation YES NO ________________________
14. Blood in bowel movements or black bowel movements YES NO ________________________
15. Problems urinating (difficulty or pain on urinating or blood in the urine) YES NO ________________________
16. Painful joints YES NO ________________________
17. Sexual difficulties YES NO ________________________
18. Depression YES NO ________________________
19. Severe sleep problems YES NO ________________________
20. Severe stress YES NO ________________________
21. Fatigue/Tiredness YES NO ________________________

21\. Other (describe) YES NO ________________________

____

How did you hear about our practice? ____

Magnolia Family Practice

Past Medical History

Name: ______________________________ Birth Date: ____________ Today's Date: ____________

Circle Yes or No for any listed conditions and explain if necessary. These are questions about **your medical history**, and pertain only to conditions **diagnosed by a doctor.**

Yes	No	1.	AIDS/HIV positive	______________________
Yes	No	2.	Anemia	______________________
Yes	No	3.	Arthritis	______________________
Yes	No	4.	Bleeding disorders	______________________
Yes	No	5.	Cancer/growth/tumor	______________________
Yes	No	6.	Diabetes	______________________
Yes	No	7.	Heart disease	______________________
Yes	No	8.	Hernia	______________________
Yes	No	9.	High blood pressure	______________________
Yes	No	10.	High cholesterol	______________________
Yes	No	11.	Kidney disease	______________________
Yes	No	12.	Liver problems	______________________
Yes	No	13.	Lung/breathing problems	______________________
		14.	Pregnancy	Total ( ) # living children ( ) miscarriages ( )
Yes	No	15.	Psychiatric/mental illness	______________________
Yes	No	16.	Rheumatic fever	______________________
Yes	No	17.	Sickle cell disease/trait	______________________
Yes	No	18.	Stroke/seizures	______________________
Yes	No	19.	Stomach problems/ulcer	______________________
Yes	No	20.	Venereal disease (STD)	______________________

Have you ever had surgery? Yes No ______________________
(please list surgery and date) ______________________
____
____
____

Have you ever been hospitalized? Yes No ______________________
(please list reason and date) ______________________
____
____
____

Past Medical History

(continued)

Name: ______________________________ Birth Date: ____________ Today's Date: ____________

Please list all medications that you take on a regular basis:

Medication Dosage How Often

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Please list any allergies you have to medicines, food, or other things:

Allergy to: Reaction:

1. ____
2. ____
3. ____
4. ____
5. ____

Social History

Marital Status: Single Married Divorced Widowed

Do you currently smoke? Yes No

Amount: ____________________ How many years: _________________

If you don't currently smoke, have you ever in the past? Yes No

Amount: __________ Total number of years: ______ When did you quit? ___________

Do you drink alcohol (even on a social basis)? Yes No

Amount (per day/week/month/year): __________ Type: ____________

Have you ever used any illegal/street drugs? Yes No

Type: ___________________ When did you last use drugs: ________________

What is your occupation? ____

Where do you work? ____

Who lives with you? ____

Family History

Name: ______________________________ Birth Date: ____________ Today's Date: ____________

Among your **blood relatives only** (children, brothers, sisters, parents, or grandparents), are any of the following illnesses present? If so, please list the relatives and any explanations. **Do not include yourself in these questions.**

Yes No 1. Bleeding disorder ____

Yes No 2. Cancer ____

Yes No 3. Diabetes ____

Yes No 4. Emotional/mental illness ____

Yes No 5. Heart problems ____

Yes No 6. High blood pressure ____

Yes No 7. High cholesterol ____

Yes No 8. Kidney disease ____

Yes No 9. Lung problems ____

Yes No 10. Seizures ____

Yes No 11. Stroke ____

Yes No 12. Thyroid problems ____

Is there any other condition not listed above which tends to run in your family?

	Condition	Explanation
1.	____________________	____________________
2.	____________________	____________________
3.	____________________	____________________
4.	____________________	____________________
5.	____________________	____________________

Health Maintenance

Name: ______________________________ Birth Date: ____________ Today's Date: ____________

When was your last tetanus shot? ________________________

When was your cholesterol last checked? __________________ Was it normal or high? ____________

Have you ever been screened for colon cancer (examination of the colon with a lighted scope)? Yes No

When was the last time? ________________

Have you ever had a blood test to check your thyroid? ___________________ When? ______________

Have you ever had the pneumonia vaccine? YES NO If yes, when? ________________

When did an eye doctor last check your eyes for glaucoma? _________________

For Men

When was your last prostate exam? __________________

Have you ever had a prostate blood test? Yes No When was the last one? ________________

For Women

When was your last period? __________________________

When was your last pap smear done? __________________________

When was your last breast exam done? __________________________

When was your last mammogram done? __________________________

Have you ever been screened for osteoporosis? YES NO If yes, when? ______________________