



FOUNTAIN HILLS FAMILY PRACTICE, PC.

# PATIENT HISTORY

Name:			Date of Birth:		Age:		Occupation:		
<b>Have you ever had or now have problems with:</b>									
	Yes	No		Yes	No		Yes	No	
Anxiety / depression			Heart Trouble			Migraines			
Asthma / emphysema			Kidney Disease			Thyroid disease			
Bleeding Tendencies			Mental Illness			Skin Issues			
Blood clots			Valley fever			Chronic back pain			
Cancer			Arthritis			Allergy Symptoms			
Diabetes			Seizures			Memory Concerns			
Glaucoma			Tuberculosis			Abnormally Tired / Fatigue			
High Blood Pressure			STD's			Chest Pain			
High Cholesterol			Stroke			Shortness of Breath			
<b>Family History</b>	<b>Age(s)</b>		<b>Medical Problems:</b>						
Father									
Mother									
Brothers No: _____									
Sisters No: _____									
<b>Have you ever had any operations? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please list:</b>									
Year	Operation		Year	Operation		Year	Operation		
List other illnesses <u>not</u> requiring an operation for which you were hospitalized:									
Do you have any <b>allergies</b> or sensitivities to medicines or other substances? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please list with type of reaction:									
Do you have any religious or cultural beliefs which may affect your care with FamilyCare? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please explain:									
<b>Medications</b> , name or otherwise identify over the counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:									
Do you have an Advance Directive (Living Will) in place? Y <input type="checkbox"/> N <input type="checkbox"/>									
Tobacco use now Y <input type="checkbox"/> N <input type="checkbox"/>		Past Y <input type="checkbox"/> N <input type="checkbox"/>		Type/amount:			How long:		
Alcohol use now Y <input type="checkbox"/> N <input type="checkbox"/>		Past Y <input type="checkbox"/> N <input type="checkbox"/>		Type/amount:			How long:		
Marijuana or street drug use now Y <input type="checkbox"/> N <input type="checkbox"/>		Past Y <input type="checkbox"/> N <input type="checkbox"/>		Type/amount:			How long:		
Check the diseases against which you have been immunized: Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Pneumovax <input type="checkbox"/> MMR <input type="checkbox"/> Tetanus <input type="checkbox"/> Polio <input type="checkbox"/> Diptheria <input type="checkbox"/> Influenza <input type="checkbox"/> Other: _____									
Date of last Pap smear:					Date of last Mammogram:				
Number of pregnancies:					Breast/Colon/Ovarian Cancer or Family History of Cancer? Y <input type="checkbox"/> N <input type="checkbox"/>				
Number of live births:					If yes, ask for Cancer Questionnaire				
Are you sexually active? Y <input type="checkbox"/> N <input type="checkbox"/>					Have you ever experienced any form of abuse? Y <input type="checkbox"/> N <input type="checkbox"/>				
Have you ever had a blood transfusion? Y <input type="checkbox"/> N <input type="checkbox"/> Date: _____									
Patient Signature: _____					Date: _____				
Physician/Provider Signature: _____					Date: _____				