Family First Health Center

Delicia M. Haynes, MD

Patient's Name _____

Date _____

Have you ever been diagnosed with any of the following conditions?

Cardiovascular (heart, arteries, veins)

Hypertension	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Valve problems	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Other _____

Respiratory (lungs)

Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Other _____

Eye

Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Other _____

Genitourinary (kidney, bladder)

Kidney stones	☐ Yes	☐ No
Urinary tract infection	☐ Yes	☐ No

Other _____

Men only

Enlarged prostate	☐ Yes	☐ No

Women only

Fibroid tumor	☐ Yes	☐ No
Pelvic inflammatory disease	☐ Yes	☐ No

Endocrine (hormones)

Diabetes	☐ Yes	☐ No

Other _____

Completed by _____

Gastrointestinal (stomach, liver, gall bladder, intestines)

Ulcer	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Reflux/heartburn	☐ Yes	☐ No
Cirrhosis/Liver	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Other _____

Neurological (brain, nerves)

Migraines	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No

Other _____

Psychiatry

Neurosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No

Other _____

Hematologic (blood, cancer)

Bleeding problem	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

If yes, where _____

Other _____

Musculoskeletal (muscles, bones)

Arthritis	☐ Yes	☐ No
Back problem	☐ Yes	☐ No
Hip/knee replacement	☐ Yes	☐ No
Bone fractures		

Other _____

Other

HIV or AIDS	☐ Yes	☐ No
Obesity	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No
Drug Abuse	☐ Yes	☐ No

Relationship to patient _____ Reviewed by _____MD