Family First Health Center
Delicia M. Haynes, M.D.

Patient Medical History Form

List medications you are currently taking: (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs etc.)

1. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
2. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
3. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
4. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
5. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
6. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
7. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
8. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
9. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
10. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

Other:_____

Medication Allergies:

Medication	Type of Reaction	Medication	Type of Reaction
1._____			
3._____			
2._____			
4._____			

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Past Surgical History: No___ Yes____ (Please circle all that apply and write in year)

Carpel tunnel (Right, Left, Bilateral)_____
Appendix Removed_____
Bladder Removed _____
Mastectomy (Right, Left, Bilateral) _____
Lumpectomy (Right, Left, Bilateral) _____
Breast Biopsy (Right, Left, Bilateral) _____
Breast Reduction _____
Breast Implants _____
Colon Cancer Resection _____
Gallbladder Removed _____
_____
Coronary Artery Bypass _____
Heart Transplant _____
_____
Knee Replacement (Right, Left, Both) _____

Hip Replacement (Right, Left, Bilateral)_____
Joint Replacement _____
Kidney Biopsy (Right, Left)_____
Kidney Removed (Right, Left)_____
Kidney Stone Removal_____
Kidney Transplant _____
Prostate Removed _____
Prostate Biopsy _____
TURP _____
Skin Biopsy (Basal cell, Squamous cell, Melanoma)

Spleen Removed _____
Testicles Removed (Right, Left, Both)

Colonoscopy: Year_____ Normal?: Y or N

Other:_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

Patient Social History (Please check all that apply)
Use of Alcohol: Never__ Rarely__ Moderate__ Daily__ How many Drinks per Week__Month__
Use of Tobacco: Never__ Daily__ Current packs/day___ Previously but quit__ Year__

Review of Systems Do you currently (**TODAY**) have any of the following? (Check all that apply)

Y__N__ Headaches
Y__N__ Diarrhea
Y__N__ Constipation
Y__N__ Blood in Stool
Y__N__ Painful Urination
Y__N__ Chest Pain
Y__N__ Shortness of Breath

Y__N__ Fever
Y__N__ Vomiting

WOMEN ONLY (Check all that apply)
Last PAP Smear Date:_____ Normal____ Abnormal____
Last Mammogram Date:_____ Normal____ Abnormal____
Last Bone Density Date:_____ Normal____ Abnormal____

REASON FOR TODAYS VISIT:_____
_____
_____
_____
_____
_____

Patient Signature_____Date_____