

# Westside Family Practice

## Patient Health History

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
OCCUPATION - CURRENT \_\_\_\_\_ PREVIOUS \_\_\_\_\_

### MAIN HEALTH PROBLEMS

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### MEDICINES you currently use (e.g. aspirin, birth control, pain pills) DOSE HOW OFTEN

- |          | DOSE  | HOW OFTEN |
|----------|-------|-----------|
| 1. _____ | _____ | _____     |
| 2. _____ | _____ | _____     |
| 3. _____ | _____ | _____     |
| 4. _____ | _____ | _____     |
| 5. _____ | _____ | _____     |
| 6. _____ | _____ | _____     |
| 7. _____ | _____ | _____     |

### OPERATIONS

DATE HOSPITAL LOCATION SURGEON

- |          | DATE  | HOSPITAL LOCATION | SURGEON |
|----------|-------|-------------------|---------|
| 1. _____ | _____ | _____             | _____   |
| 2. _____ | _____ | _____             | _____   |
| 3. _____ | _____ | _____             | _____   |
| 4. _____ | _____ | _____             | _____   |
| 5. _____ | _____ | _____             | _____   |
| 6. _____ | _____ | _____             | _____   |
| 7. _____ | _____ | _____             | _____   |

### HOSPITALIZATIONS for major illness (e.g. heart attack, diabetes, cancer, arthritis, fracture)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### ALLERGIES TO MEDICINES

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### PREVIOUS TESTS

	Yes	No	Results	Date	Where
X-RAYS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
CHEST	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
UGI (Stomach)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
BE (Colon)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
IVP (Kidney)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
ULTRASOUND	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
CT/MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**HABITS**

TYPE OF EXERCISE \_\_\_\_\_  
ALCOHOL USE \_\_\_\_\_ oz/week  
TOBACCO USE \_\_\_\_\_ cigarettes/week

**FEMALE HISTORY**

AGE AT ONSET OF MENSES \_\_\_\_\_  
NUMBER OF PREGNANCIES \_\_\_\_\_  
NUMBER OF LIVE BIRTHS \_\_\_\_\_  
NUMBER OF MISCARRIAGES \_\_\_\_\_  
BIRTH CONTROL METHOD \_\_\_\_\_

**SOCIAL HISTORY**

BIRTHPLACE \_\_\_\_\_ LIVED OUTSIDE OF USA?  Y  N IF SO, WHERE? \_\_\_\_\_

MARITAL STATUS  MARRIED  DIVORCED  WIDOWED  SINGLE  SEPARATED

NAME OF SPOUSE \_\_\_\_\_ RELIGIOUS AFFILIATION \_\_\_\_\_

CHILDREN'S NAMES	BIRTH DATES	CHILDREN'S NAMES	BIRTH DATES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PAST MEDICAL HISTORY**

HAVE YOU EVER HAD SERIOUS OR RECURRENT:

- SICK HEADACHE OR MIGRAINE
- BLURRED/DOUBLE VISION
- NOSEBLEEDS
- HAY FEVER/SINUS TROUBLE
- PNEUMONIA/PLEURISY
- CHRONIC COUGH
- ASTHMA/WHEEZING
- SHORTNESS OF BREATH
- HIGH BLOOD PRESSURE
- IRREGULAR/FAST HEARTBEAT
- SWOLLEN ANKLES
- HEAT ATTACK/ANGINA
- HEARTBURN/INDIGESTION
- ULCERS
- CHANGE IN BOWEL HABITS
- DIVERTICULITIS/IRRITABLE BOWEL
- BLOODY/BLACK STOOLS
- HEMORRHOIDS
- JAUNDICE/HEPATITIS
- URINE INFECTION/BLOODY URINE
- LOSS OF CONTROL OF URINATION
- DECREASED FORCE OF URINATION
- KIDNEY STONE
- SEXUALLY TRANSMITTED DISEASE(S)
- RASH/HIVES
- RECENT FATIGUE
- RECENT CHANGES IN WEIGHT
- NERVOUSNESS/DEPRESSION
- ABNORMAL PAP
- CONCERNS ABOUT AIDS?

**FAMILY HISTORY**

	LIVING	DECEASED
FATHER	_____	_____
MOTHER	_____	_____
BROTHER	_____	_____
BROTHER	_____	_____
BROTHER	_____	_____
BROTHER	_____	_____
SISTER	_____	_____
SISTER	_____	_____
SISTER	_____	_____
SISTER	_____	_____

WHO HAS HAD  
(abbreviate: F=Father, M=Mother, B=Brother, S=Sister)

HEART DISEASE	_____
STROKE	_____
CANCER (TYPE)	_____
DIABETES	_____
LUNG DISEASE	_____
MIGRAINE	_____
MENTAL ILLNESS	_____
KIDNEY DISEASE	_____
ARTHRITIS	_____