Marchand & Associates
FAMILY MEDICINE

Your Provider: Dr._____

HEALTH HISTORY

Name: _____ Date of Birth: _____ Date: _____

What brings you to the clinic today? _____

PREVIOUS OR ONGOING MEDICAL PROBLEMS

PROBLEM	ONSET	RESOLVED/ONGOING

SURGERIES

TYPE OF SURGERY	DATE	SURGEON (IF KNOWN)

Are you allergic to any medications? YES NO If yes, what medication and what reaction do you have?

_____

_____

_____

CURRENT MEDICATIONS/VITAMINS

MEDICATION	WHAT IS IT FOR?	DOSE	DIRECTIONS

FOR WOMEN:
Start date of last menstrual period:_____
# of pregnancies:_____
# of vaginal deliveries:_____Date(s):_____
# of C-Sections:_____Date(s):_____
# of miscarriages:_____# of abortions_____
Do you use birth control? YES NO Type?_____

FOR CHILDREN:
Are you up to date on vaccinations? YES NO
Please provide copy of shot record if available
Any developmental or childhood disorders? YES NO
Please explain:_____

Name: _____

Date of Birth: _____

FAMILY HISTORY

FAMILY MEMBER	HEALTH PROBLEMS	AGE OF ONSET	CAUSE OF DEATH, IF DECEASED
Mother			
Father			
Brother			
Sister			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Aunt			
Uncle			
Other_____			

Use the list of diseases below and any other significant findings to fill in the appropriate boxes above:

ALCOHOLISM	ANEURYSM	ARTHRITIS	BREAST CANCER
COLON CANCER	CANCER (Type)_____	DIABETES	GLAUCOMA
GALLSTONES	HEART DISEASE	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL
MENTAL ILLNESS	POLYCYSTIC KIDNEY	SEIZURES	SUICIDE
THYROID DISORDER	TUBERCULOSIS		

SOCIAL HISTORY

Do you smoke? YES NO PREVIOUSLY If yes, how many packs per day? _____For how long? _____

Have you ever been exposed to second hand smoke? YES NO

Do you drink Alcohol? YES NO If yes, how many drinks per week? _____

Do you now or have you ever used illicit drugs? YES NO If yes, what kind? _____

Do you participate in any sexual activity that could be considered risky? _____

Do you use seatbelts regularly? YES NO

Do you exercise regularly? YES NO If yes, what type and how often? _____

Have you ever been exposed to chemical or other harmful substances YES NO Please Explain: _____

Did you have radiation treatment as a child? YES NO

Did your mother take hormones while she was pregnant with you? YES NO UNKNOWN

When was your last dental exam? _____

Do you have an advanced care directive? _____

HEALTH MAINTENANCE

TEST OR IMMUNIZATION	DATE OF LAST	RESULT (IF KNOWN)
Physical Examination		
Cholesterol Test		
PSA (Prostate screening)		
Colonoscopy		
Pap Smear		
Mammogram		
Bone Density		
Tetanus or Tdap booster		
Hepatitis A series		
Hepatitis B series		
Pneumovax		
Other _____		

In planning for future health care for you, we would like to know what extra health services you feel you might want or need. In addition to caring for you when you are sick, what else for you when you are sick, what else would you like your doctor to do for you?