CREDO
FAMILY MEDICINE

Patient History Form

Patient Name: _____ **Patient No.**: _____

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: ___M ___F **Birthplace**:_____

Previous Primary Physician: _____ **Last Visit**: _____

Social History

Marital Status:	Single: ____	Married: ____	Separated: ____	Widowed: ____
Spouse Name:		*Partner Name:*		
Race:		**Ethnicity:**	**Primary Language:**	
Who lives in the home?				
Pets?		*Do they sleep with you? Yes: ____ No: ____*		
Occupation:		**Religious Preference:**		
Highest Level of Education:	High School:____	College:____	Graduate:____	Post Graduate: ____
Alcohol Use:	Never: ____	Current: ____	Former: ____	*Amount per week:* _____
If Former, how long ago was last use?:				
Drug Use:	Never: ____	Current: ____	Former: ____	*Type used:* _____
If Former, how long ago was last use?:				
Smoking Use:	Never: ____	Current: ____	Former: ____	Secondhand:____ *Amt per day:* _____
If Former, how long ago was last use?:				
Exercise Frequency:	Heavy: ____	Medium: ____	Minimal: ____	None: _____
Activity Description (gym, running, walking, etc.):				
Living will/POA?	Yes: ___ No: ___	***Will you accept emergency blood transfusions?***	Yes: ___ No: ___	

Medical History

Preventative Care			
When was your last?	Date	Abnormal	Normal
Colonoscopy			
PAP Smear			
Mammogram			
Bone Density Scan			
Lung Cancer Screening			
Skin Check			
Eye Appointment			
Tetanus Shot			
Last TB			
Last Blood Work			
Are you up to date with vaccinations?	Yes: ____ No: ____ Delayed Schedule: ____ Refused: ____		

Patient Name: _____

If "Yes" please indicate the approximate date the condition occurred.

Condition	Yes	Date	No	Condition	Yes	Date	No
Abnormal PAP Smear				Heartburn			
Alcoholism				Hemorrhoids			
Anemia				Hepatitis			
Anesthesia Complication				Herpes			
Aneurysm				High Cholesterol			
Anxiety				HIV/AIDS			
Arrhythmia				Hypertension			
Arthritis				Hyperthyroidism			
Asthma				Hypothyroidism			
Bleeding Disorder				Infertility			
Blood Clotting Disorder				Irritable Bowel Syndrome			
Blood Transfusion				Kidney Disease			
Breast Cancer				Kidney Stone			
Breast Disorder				Liver Disease			
Cancer, other				Lupus			
Colon Polyps				Mental Illness			
Congestive Heart Failure				Migraine			
Coronary Artery Disease				Muscle Pain			
Crohn's Disease				Osteoporosis			
Depression				Pacemaker			
Diabetes				PCOS			
Dialysis				Pelvic Inflammatory Dis.			
Diverticulitis				Prostate Enlargement			
Eczema				Psychiatric Disorder			
Emphysema/COPD				Pulmonary Embolism			
Endometriosis				Seasonal Allergies			
Epilepsy				Seizures/Convulsions			
Eye Problems				Sexually Transmitted Dis.			
Fibromyalgia				Sickle Cell Anemia			
Frequent Infections				Stroke			
Gall Bladder Disease				Suicide Attempts			
Glaucoma				Tuberculosis			
Gout				Ulcers			
Heart Attack				Urinary Tract Infection			
Heart Disease				Urination Problems			
Heart Murmur				***Other, please specify:***			

Newborn Pediatric Patients (please check all that apply)					
___*Vaginal*	___ *C-section*	___*Preterm*	___ *Full Term*	___*Shoulder Dystosia*	___*NICU Admit*
Pregnancy Complications (i.e. diabetes, hypertension)?					

Patient Name: _____

Please list any medications, supplements, vitamins, or herbals that you take.

Medication	Dosage	Frequency
1)		
2)		
3)		
4)		
5)		

Allergies	Reaction	Age First Occurred
1)		
2)		
3)		

Surgeries/Hospitalizations	Date	Reason
1)		
2)		
3)		
4)		

Female Reproductive History							
Age of First Menses:		Duration in Days:		Cycle Length in Days:			
Last Menstrual Period		Is this date certain?		Yes: ____ No: ____			
Typical Menses Flow:	___ Heavy ___ Moderate ___ Light			Average # of Pads/Tampons per Day:			
Menopause Status:	___ Pre ___ Peri ___ Post			Age of Menopause:			
Have you had:	Breakthrough bleeding? ____	Blood Clots? ____		Hormone Replacement Therapy? ____			
Do you use natural family planning? If so, what method?							
Do you use birth control? If so, what kind?							

Pregnancy History							
Total Pregnancies	Number of Full Term	Number of Preterm	Number of Miscarriages	Number of Abortions	Ectopic Pregnancies	Multiple Births	Number Living
Date	Gestational Age	Hours in Labor	Birth Weight	Type of Delivery	Anesthesia	Which Hospital?	
Comments or complications?							

Patient Name: _____

Family History

Family Health Status							
Are you adopted?	_____	**No. of Siblings**:	Living: ____ Deceased: ____		**Birth Order:**	_____	
No. of Children:			**No. of Grandchildren:**				
	Alive	**Health Status**		**Deceased**	**Cause of Death**		**Age Died**
Father							
Mother							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Please indicate the relationship (i.e. uncle, sister, etc.) and check either the paternal or maternal column.

Illness Among Relatives	Relationship	Paternal	Maternal
Alcoholism/Drug Use			
Blood Clot			
Brain Aneurysm			
Cancer			
Colon Polyp			
Depression			
Diabetes			
Glaucoma			
Heart Attack – *what age*?			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Hypertension			
Kidney Disease			
Mental Illness			
Osteoporosis			
Seizures			
Stroke – *what age*?			
Thyroid Disease			
Other, please specify:			