TUCSON FAMILY MEDICINE HEALTH HISTORY FORM MRN _____

MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Marital Status: M [ ] S [ ] D [ ] W [ ] How many children do you have? _____

Current Occupation? _____

If retired, what kind of work did you do? _____

PLEASE LIST ANY MEDICATION(S) YOUR ARE CURRENTLY TAKING WITH DOSAGE AND FREQUENCY:

	Medication	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION:

	Medication	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS AND/OR SURGERY YOU HAVE AND/OR HAD, EVEN AS A CHILD
(Such as diabetes, high blood pressure, cancer, heart disease, etc.)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

FAMILY HISTORY

Medical Condition(s) (such as diabetes, high blood pressure, cancer, heart disease, etc.) Status: Age:

Mother _____ Living/Deceased _____

Father _____ Living/Deceased _____

Siblings _____ Living/Deceased _____

Other close relatives _____ Living/Deceased _____

Social History

Are you a current smoker? _____ Have you every smoked? _____ Approximate # years smoking? _____

Most pack per day smoked? _____ Any other tobacco products used? (if so list) _____

Have you quit? _____ If yes, what year? _____

Do you drink alcohol? ____ If yes, what kind? Beer # per day ___Wine # per day ___ Hard liquor Oz per day ___

Have you ever had a problem with alcohol? _____ If yes, explain _____

Have you ever used recreational drugs? If yes, what kind _____

Do you exercise regularly? _____ What kind? _____ How often? _____

Who else lives at home with you? (ie: parents, spouse, children, caregiver, friends, etc. (names not needed)

_____

Have you ever had a shot to prevent pneumonia? ____ if so, what year? _____

Have you ever had a shot to prevent shingles? ____ if so, what year? _____

Last Tetanus shot _____ Last Flu shot _____

Have you ever had a colonoscopy? _____ if yes, when _____ Result was: Normal or Abnormal?

Last Mammogram _____ Result was: Normal or Abnormal?

Last Pap (if you have a cervix) _____ Result was: Normal or Abnormal?

Last Dexa Scan _____ Result was: Normal or Abnormal?

Last Glaucoma/Eye Exam _____ Result was: Normal or Abnormal?

Are you sexually active? _____

Are you sexually active with a male? _____ Are you sexually active with a female? _____

Comments: _____