

Colorado Springs Family Practice

Health History

Name: _____ Date of Birth: _____ Date: _____

Address: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Employer: _____ Occupation: _____

To help us meet all of your healthcare needs, please print and fill out **both sides** of this form completely with an **ink pen**. This is a confidential record of your medical history and will be kept in this office.

DRUG ALLERGIES/REACTIONS:

CURRENT MEDICATIONS:

HABITS:

Tobacco Use: No Yes - cigarettes - cigar - pipe - dip/snuff

Amount per day _____ Interested in stopping? No Yes

If former smoker, date quit _____

Alcohol Use: No Yes Drinks per week _____

Caffeine: No Yes Amount per day _____

Street Drugs: No Yes Type _____ Amount per day _____

Exercise: No Yes -Aerobics -Resistance How often: _____

Do you use seatbelts? Yes No

Have you been out of the country in the last 60 days? _____ Where? _____

YEAR OF LAST:

Physical Exam _____

Pneumonia Vaccine _____

Hepatitis B Series _____

Tetanus Vaccine _____

Colonoscopy _____

Cholesterol Test _____

Influenza Vaccine _____

Date of Last Chest X-Ray: _____

OVER:

Family History:

	Father	Mother	Paternal	Maternal	Siblings	Children
Heart Disease	<input type="checkbox"/>					
High Blood Pressure	<input type="checkbox"/>					
Stroke	<input type="checkbox"/>					
Cancer	<input type="checkbox"/>					
Glaucoma	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>					
Epilepsy/Convulsions	<input type="checkbox"/>					
Bleeding Disorder	<input type="checkbox"/>					
Kidney Disease	<input type="checkbox"/>					
Thyroid Disease	<input type="checkbox"/>					
Mental Illness	<input type="checkbox"/>					
Osteoporosis	<input type="checkbox"/>					

Father- Alive Deceased Date: _____

Mother- Alive Deceased Date: _____

Brother(s) - Alive Deceased Date: _____

Sister(s) - Alive Deceased Date: _____

Paternal Grandfather- Alive Deceased Date: _____

Paternal Grandmother- Alive Deceased Date: _____

Maternal Grandfather- Alive Deceased Date: _____

Maternal Grandmother- Alive Deceased Date: _____

MEN ONLY:

Discharge from penis No Yes

Pain or lump in testicles No Yes

Impotence No Yes

Date of last Prostate Exam _____

Sexual Active: Yes No If yes: Same Partner Different Partners

WOMEN ONLY:

Age period began _____

How many days do periods last? _____

How many days between periods _____

Is the flow heavy No Yes

Do you bleed or Spot between periods No Yes

Do you have pain or cramps No Yes

Are you menopausal No Yes

Date of last period _____

Date of last pelvic exam _____

Date of last mammogram _____

Pain with intercourse No Yes

Contraception used _____

Sexually Active: Yes No If yes: Same Partner Different Partners

Over:

Last Name: _____

First Name: _____

Date: _____

PAST MEDICAL HISTORY:

Have you ever had the following?

- | | | | | | | | | |
|---------------------------------------|-----------------------------|------------------------------|--------------------------|-----------------------------|------------------------------|--|-----------------------------|------------------------------|
| Measles | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Migraine Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hives or Eczema | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Mumps | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | AIDS or HIV | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chickenpox | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Infectious Mono | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Whooping Cough | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bronchitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Acne | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Scarlet Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Polio | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mitral Valve Prolapse | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diphtheria | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Glaucoma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Smallpox | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hernia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Pneumonia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Stones | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tumors | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Ulcers | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Please List: _____ | | |
| Pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Anxiety | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | | |
| Rheumatic Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Scoliosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Grave Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Any other Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Venereal Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | ADHD | <input type="checkbox"/> No | <input type="checkbox"/> Yes | (Please List) _____ | | |
| Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Immune Deficiency | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | | |
| Bladder Infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hemorrhoids | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Epilepsy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nasal Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> High <input type="checkbox"/> Low | | |
| Ear Infections | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diverticulitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Low/High Thyroid | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hearing Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Irritable Bowel Syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Low/High Cholesterol | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Psoriasis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Easy Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sciatica | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Easy Bruising | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Panic Attacks | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatoid Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fibromyalgia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bipolar Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Degenerative Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | ADD | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Post-Traumatic Stress Disorder (PTSD) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | | | |
| Precancerous Growths | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | | | |
| | | | | | | Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | | | | If Yes, Please List: _____ | | |
| | | | | | | _____ | | |

Addiction No Yes
If Yes, Please list: _____

Previous Physician: _____ Location: _____

LIST PREVIOUS HOSPILIZATIONS AND SURGERIES WITH DATES OF EACH:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing Incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize Colorado Springs Family Practice to perform the necessary healthcare services I (my child) may need.

X _____
Signature of Patient or parent if minor

Date _____