

# Colorado Springs Family Practice

## Health History

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone(Home) \_\_\_\_\_ (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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**CURRENT MEDICATIONS**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### HABITS

Smoking (type & amount per day) \_\_\_\_\_  
If former smoker, date quit \_\_\_\_\_  
Alcohol (type & amount per week) \_\_\_\_\_  
Caffeine (type & amount per day) \_\_\_\_\_  
Street Drugs (type & amount per day) \_\_\_\_\_  
Exercise (type & frequency) \_\_\_\_\_  
Do you use seatbelts?  Yes  No

### YEAR OF LAST:

Physical Exam \_\_\_\_\_  
Colonoscopy \_\_\_\_\_  
Cholesterol Test \_\_\_\_\_  
Influenza Vaccine \_\_\_\_\_  
Pneumonia Vaccine \_\_\_\_\_  
Hepatitis B Series \_\_\_\_\_

### 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"/>					

### MEN ONLY:

Discharge from penis  No  Yes  
Pain or lump in testicles  No  Yes  
Impotence  No  Yes  
Date of last Prostate Exam \_\_\_\_\_

### 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 \_\_\_\_\_  
Any itching in vaginal area  No  Yes  
Pain with intercourse  No  Yes  
Type of birth control used \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of full term births \_\_\_\_\_  
Number of pre term births \_\_\_\_\_  
Any family history of: Relationship  
Breast cancer  No  Yes \_\_\_\_\_  
Cervical cancer  No  Yes \_\_\_\_\_  
Uterine/Ovary cancer  No  Yes \_\_\_\_\_

-OVER-

