Albemarle Center for Family Medicine
Patient Health History

Patient Full Name:_____ DOB:_____

Date of Exam:_____

Please list any specialists and their contact information that you see on a regular basis:

_____

_____

Past Medical History: PLEASE CIRCLE ANY CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH PREVIOUS TO TODAY'S VISIT

Acne Allergic Rhinitis Anxiety Anxiety and Depression

Aortic Valve Disorder Concussion Depression Depression with Anxiety Easting Disorder

Elevated ALT Hypertension Exercise Induced Asthma Fatigue GERD Goiter Herpes Genitalis

Hyperlipidemia Hypothyroid Impaired Fasting Glucose Insomnia Migraine Obesity Osteopenia

Sleep Apnea Reactive Airway Disease Vit D Deficiency PCOS

Past Surgical History: Please indicate which of the following surgeries you have had and when they took place.

Abdominal _____ Appendectomy_____ Tonsillectomy_____ Cesarean Section_____

CABG_____ Cataract_____ Gall Bladder_____ Colonoscopy_____

Hernia_____ Hysterectomy_____ Vasectomy_____ Pacemaker_____

Tumor Removal_____ Blood Transfusion, when? _____ Heart, what kind?_____

Orthopedic, what kind and when? _____

Other major surgeries? _____

Current Medications: Please indicate the name, dosage and instructions for each medication that you take.

_____ _____

_____ _____

Any Allergies to Medications? ☐ **No** ☐ **Yes**

If so, please indicate the name of the medication(s) and the reaction(s) you have had to that medication.

_____ _____

Family Medical History: Please circle which of the following conditions are present within your immediate family.

M=Mother, F=Father, B=Brother, S=Sister, MG= Maternal Grandmother, MGF= Maternal Grandfather, PG= Paternal Grandmother, PGF= Paternal Grandfather

Atrial Fibrillation_____	ADD/ ADHD_____	Allergic Rhinitis_____	Arthritis_____
Asthma_____	Anxiety_____	COPD_____	Heart Valve _____
Heart Disease_____	Stroke_____	Depression_____	Diverticulitis_____
Embolism_____	Osteoporosis_____	Diabetes (Type I or II)_____	Heart Attack_____
High Cholesterol_____	Dementia_____	High Blood Pressure_____	Blood Clots_____
Reflux / GERD_____	Thyroid Condition_____	Headaches / Migraines_____	
Cancer, Types_____		Peripheral Vascular Disease_____	

Reproductive History:

Menstrual Cycles:

Age of first menses: _____ How many days are in between each period? _____

How many days do your periods last?_____ Menstrual Flow: ☐ LIGHT ☐ MEDIUM ☐ HEAVY

Last Menstrual Period: _____ Method of birth control: _____

Menopause Status: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal Age of menopause: _____

Pregnancy:

Total Pregnancies:_____ # Full Term: _____ #Premature:_____ # Miscarriages:_____ #Multiples:_____

#Living, with ages:_____

Social History: Please indicate which of the following apply to your current lifestyle.

Do you use any of the following:

Tobacco Use: ☐ Current Smoker, how much? _____ ☐ Former, quit when?_____ ☐ Never

Caffeine Use: ☐ Daily ☐ Occasional ☐ Never

Alcohol Consumption: ☐ Daily ☐ Occasional ☐ Never

Illicit / street drug use: ☐ Daily ☐ Occasional ☐ Never

Do you have any of the following cognitive impairments;

☐ Blind or serious difficulty seeing ☐ Deaf or serious difficulty hearing

☐ Memory Impairment ☐ No Impairment

Do you have any physical impairments that we need to be aware of:

☐ Has a mild physical impairment ☐ Has a moderate physical impairment

☐ Has no physical impairment ☐ Has a significant physical impairment

☐ Walks with a cane / assistance

What is your occupation: _____ Are you retired, when? _____

Are you:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Are you a:

☐ Child, living with both parents ☐ Adopted Child ☐ Foster Child

☐ Child, living with one parent / guardian. Who? _____

Do you have a history of domestic violence? ☐ YES ☐ NO ☐ DECLINE TO COMMENT

☐ Emotional ☐ Sexual ☐ Physical

Would you like information about resources for victims of domestic violence? _____

What is your current education level? If school aged, what grade and school does the child attend?_____

☐ Day Care ☐ Pre-School ☐ Home School ☐ Elementary School ☐ Middle School ☐ High School

☐ Undergraduate ☐ Masters ☐ PhD. / MD

Tell us about your exercise habits:

How many times per week do you exercise? _____ For how long each time?_____

Type of exercise / activity_____

Have you traveled outside of the US in the last 90 days?

☐ If so, where have you traveled? _____

☐ No recent travel history