**Kennestone Family Medicine**

**Comprehensive Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

**May we discuss medical/billing information with another person other yourself; if so please list**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill out the following information so that we have an understanding of your current medical status**

**Current Medications** (name of the drug and dosage):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies** Please check or list drugs and the type of reaction:

□ I am not allergic to any medications

□ Penicillin Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Latex Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Sulfa Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Food Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other medication (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Problems**: Have you had (or do you have now) any of the following medical problems:

□ High Blood Pressure □ Cancer □ Asthma □ Kidney stone

□ Diabetes □ Depression/anxiety □ Headache/migraine □ Glaucoma/cataract

□ Heart Disease □ Anemia □ Chronic pain □ Dementia/memory loss

□ High cholesterol □ Stroke/TIA □ Fibromyalgia □ Seizure Disorder

□ Acid reflux □ Hepatitis-B/C □ Gout □ Positive HIV/AIDS

□ Thyroid disease □ DVT/PE □ Arthritis □ Sexually transmitted diseases

□ COPD □Other(Describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgery or Hospitalizations**:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

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**Smoking and Alcohol History**

Cigarettes: Do you smoke now □ Yes □ No Have you smoked in the past: □ Yes □ No

How many years did you smoke:\_\_\_\_\_ When did you quit: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use other tobacco products: □ No □ Cigars □ Chewing Tobacco □ snuff □ other

How much alcohol do you drink: □ None □ 1-7 drinks/week □ 8-14 drinks/week □more than 14

**Social History**

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse and Children’s name & ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee/Tea: Cups or glasses per day:\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise regularly: □ Yes □ No

In the last year have you traveled outside the country: □ Yes □ No If yes, where:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pets at home: □ Cats □ Dogs □ Fish □ Birds □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**: for blood relatives only; check if any relative had any of the following diseases

For parents and grandparents, please enter the current age if living, or age at the time of health if deceased, and check if they had any of these diseases.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Living? | Age | High Blood  Pressure | Heart  Disease | Diabetes | Colon  Cancer | Breast/prostate  Cancer | Other  Cancer | Other problems  ( describe) |
| Father | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| Grandfather | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| Grandmother | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| Mother | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| Grandfather | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| Grandmother | □ Y □ N |  | □ | □ | □ | □ | □ | □ |  |
| AnyBrother/Sister |  |  | □ | □ | □ | □ | □ | □ |  |

**Other diseases in your family:**

□ Stroke □ Tuberculosis □ Goiter

□ Kidney Disease □ Sickle Cell □ Bleeding problems

□ Asthma □ Leukemia □ Psychiatric problems

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**(or person completing form)**