

Name:

Longneck Family Practice – Health History

Date:

Have YOU had? (Please circle Y or N Answer)

- 1. Heart trouble Y N
- Heart attack (MI) Y N
- Angina/chest pain with exertion Y N
- Shortness of breath Y N
- 2. Blood pressure problems Y N
- 3. Diabetes Y N
- 4. Asthma Y N
- 5. Bronchitis, Emphysema, or other lung disease Y N
- 6. Seizure disorder/fainting Y N
- 7. Hepatitis, liver, pancreas disease Y N
- 8. Thyroid problems Y N
- 9. Arthritis, joint, back pain Y N
- 10. Sickle Cell trait or disease Y N
- 11. Phlebitis or blood clots Y N
- 12. Stroke Y N

What deficits/weakness do you have?

- 
- 13. Bleeding problems Y N
  - 14. Vision Problems Y N
  - 15. Hearing Problems Y N
  - 16. Recent weight gain or loss Y N
  - 17. Urination at night Y N
  - 18. Urgency/difficulty leaking urine Y N
  - 19. Constipation/diarrhea Y N
  - 20. Bloody/tarry stools Y N
  - 21. Is your fluid intake limited? Y N
  - 22. Are you on a special diet? Y N
  - 23. Stomach pains Y N
  - 24. History of Cancer Y N
  - 25. Allergies to drugs Y N
  - 26. Other allergies Y N
  - 27. Ever had a blood transfusion Y N

OBGYN History

- 1. # times pregnant \_\_\_\_\_ Abortions \_\_\_\_\_  
miscarriages \_\_\_\_\_
- 2. # of children \_\_\_\_\_
- 3. Age periods started \_\_\_\_\_ Age they stopped \_\_\_\_\_
- 4. Currently on Birth control Y N  
Method \_\_\_\_\_

If you answered "Y" to any question on this page, please provide more details here or on the bottom of Pg 2.

- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_
- # \_\_\_\_\_

Please list previous biopsies, endoscopies, and surgeries you had either hospitalized or as an outpatient.

Type and Date:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_

Previous Hospitalizations other than above:  
List date and reasons

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

List medications you are presently taking. Include non-prescription and over the counter pills, herbals, vitamins. Please include the Dosage and frequency of each pill.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

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**Social History – Do you?**

1. Presently Smoke/use tobacco            Y     N  
     # Packs a day? \_\_\_\_\_  
     # of Years? \_\_\_\_\_  
     If no, when did you quit? \_\_\_\_\_

2. Drink alcohol?                                Y     N  
     # per 7 days? \_\_\_\_\_

3. Recreational drug use                      Y     N

4. Been tested for AIDS                        Y     N

5. Have Sleep problems                        Y     N

6. History of Chicken Pox                      Y     N

7. Caffeine Use                                    Y     N  
     # 8oz cups a day \_\_\_\_\_

8. Do you have a Living Will  
     or Advanced Directives                    Y     N

9. Highest Level of Education: \_\_\_\_\_

10. Occupation: \_\_\_\_\_

11. Marital Status: M / S / D / W / Partners  
     Name: \_\_\_\_\_

12. What kind of pets? \_\_\_\_\_

13. Travel History outside the U.S.  
     \_\_\_\_\_

14. Hobbies: \_\_\_\_\_

**Preventative History (Please put the Date)**

Last Pap Smear: \_\_\_\_\_ Result \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ Result \_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_ Result \_\_\_\_\_

**Immunizations (Please put the Year of last one)**

Tetanus Booster: \_\_\_\_\_ Flu Shot: \_\_\_\_\_

Pneumovax Shot: \_\_\_\_\_ Shingles Shot: \_\_\_\_\_

Hepatitis B Shots: \_\_\_\_\_ Hep A Shots: \_\_\_\_\_

Gardasil (HPV): \_\_\_\_\_ Menactra: \_\_\_\_\_

Last Cholesterol level: \_\_\_\_\_

Last Blood Sugar: \_\_\_\_\_

Last PSA: \_\_\_\_\_

**Consultant List: Please list other doctors that will be treating you. (Name and specialty)**

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

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

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

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

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

Relatives	Age if living	Age and year of death	Current Illness	Cause of Death
Father				
Mother				
Other Family:				

Additional Comments: (use this space to complete any of the history or for other comments)