Family Care Associates of Effingham S.C.

MEDICAL HISTORY FORM

Date ____________ Chart # ____________

Name ________________________

Birth Date ____________ Age ______

Address ________________________

____

Home Phone# ________________________

Work Phone # ________________________

Occupation ________________________

Employer ________________________

Height ____________ Weight ____________

Married ________ Single ________ Divorced ________

Separated ________ Widowed ________

Spouse's Name ________________ Age ______

Children's ________________ Age ______

Names ________________ Age ______

________________ Age ______

________________ Age ______

OPERATIONS, INJURIES, OR HOSPITALIZATION	Date	Medical problems	Date

Medications now being taken, including over the counter products and birth control pills	Allergies and/or medication reactions (Penicillin, Sulfa, ect.)

IMMUNIZATIONS: (date of last shot/test)

Flu ________ Tetanus ________ Rubella ________

Tuberculin ________ Polio ________

Pneumonia ________ Hepatitis ________

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐
Breathing Problems	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐	☐	☐
Other - Specify ________	☐	☐	☐	☐	☐	☐

SYSTEMS REVIEW: Are you troubled with any of the following:

General	YES	NO
Unexplained weight loss	☐	☐
Excessive Thirst	☐	☐
Excessive Fatigue	☐	☐

Skin and Hair	YES	NO
Any skin or hair problem	☐	☐

Eye, Ear, Nose & Throat	YES	NO
Eye Problem	☐	☐
Ear Problem	☐	☐
Nose Problem	☐	☐
Hoarseness	☐	☐
Trouble Swallowing	☐	☐

Heart and Lungs	YES	NO
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Coughing up Blood	☐	☐
Chest Pain	☐	☐
Wheezing	☐	☐
Chest Discomfort with Exercise	☐	☐
Irregular Heart Beat	☐	☐
Other Heart Trouble	☐	☐
Ankle Swelling	☐	☐
Chest X-ray in Last Year	☐	☐
Have You Ever had an EKG	☐	☐

Intestinal System	YES	NO
Weight Loss	☐	☐
Appetite Loss	☐	☐
Frequent Indigestion	☐	☐
Heartburn	☐	☐
Frequent Belching	☐	☐
Abdominal Pain	☐	☐

Intestinal System (Continued)	YES	NO
Frequent Nausea & Vomiting	☐	☐
Change in Bowel Habits	☐	☐
Persistent Constipation	☐	☐
Frequent Diarrhea	☐	☐
Rectal Bleeding	☐	☐
Rectal Itching or Soreness	☐	☐

Urinary System	YES	NO
Painful Urination	☐	☐
Passing Blood	☐	☐
Poor Bladder Control	☐	☐
Weak Stream	☐	☐
Urination more than once a night	☐	☐

Skeleton and Joints	YES	NO
Pain in Joints	☐	☐
Swelling in Joints	☐	☐
Back Trouble	☐	☐

Nervous System	YES	NO
Severe Headaches	☐	☐
Numbness of Hands & Feet	☐	☐
UncontrollableTension	☐	☐
Increased Irritability	☐	☐
Feelings of Being "Blue"	☐	☐
Suicidal Thoughts	☐	☐

Personal Problems (health, family and business)	YES	NO
Problems with Sexual Relations	☐	☐
Have you had Psychiatric Help	☐	☐
Do you desire Psychiatric Help	☐	☐

Habits	YES	NO	***If Yes, Average Amount***
Whiskey	☐	☐	______
Beer	☐	☐	______
Wine	☐	☐	______
Coffee	☐	☐	______
Mixed Drinks	☐	☐	______

Do You Smoke? YES NO

If so, how much ______ (Packs per Day)

For how long? ______

Do you use or ever used drugs? (marijuana, cocaine, opiates, LSD, other)

FOR WOMEN ONLY	YES	NO
Have you ever had an abnormal Pap Smear?	☐	☐
Are your periods irregular?	☐	☐
Do you bleed between periods?	☐	☐
Do you take birth control pills?	☐	☐
Do you have an IUD?	☐	☐
When was your last period? ______	☐	☐

How long is it between periods? ______

How many days do you flow? ______

Amount: Small ______ Moderate ______ Heavy ______

When was last Pap Smear? ______

No. of Pregnancies ______

No. of Living Children ______

No. of Miscarriages ______

No. of Abortions ______

Last Mammogram ______

FOR MEN ONLY

Have you had any of the following:

	YES	NO
Sore on penis?	☐	☐
Discharge from penis?	☐	☐
Swelling or tenderness of scrotum?	☐	☐
Any problems with sex function?	☐	☐
Any problems having children?	☐	☐
Prostate trouble?	☐	☐
Have you had a Vasectomy?	☐	☐
Have you ever had an instrument passed into the bladder?	☐	☐