Pt. #_____

North Country Family Practice
Personal and Family History Form

8/3/15

Name:_____ Date of birth:_____ Date:_____

Current or Past Medical Problems: (please circle all that apply)

Anemia	Diabetes – Juvenile	Elevated Cholesterol	Urinary Incontinence
Arthritis	Diabetes – Gestational	Hypertension	UTI
Asthma	Chronic Ear Infections	Hyperthyroidism	Varicose Veins
Cancer:_____	Endometriosis	Hypothyroidism	Other:
Cataracts	Gastro-Esophageal Reflux	Kidney Stones	
Stroke	Glaucoma	Meningitis	
Cirrhosis	Gout	Muscular Dystrophy	
Colitis	Headaches	Multiple Sclerosis	
Congestive Heart Failure	Heart Disease	Osteoporosis	
Constipation	Heart Attack	Peptic Ulcer Disease	
Chronic Lung Disease	Hemorrhoids	Pneumonia	
Depression	HIV	Sexually Transmitted Disease	
Diabetes – Adult onset	ADD	Ulcers	

Drug or food allergies and reaction:_____

Medication List

Please include prescription medication name, your dosage, and prescribing doctor. Include all over-the-counter medications, herbs, and vitamins.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____

Immunization History: (Write in date of most recent – Bring immunization record)

Tetanus:_____ Hepatitis B:_____ Hepatitis A:_____
MMR:_____ Pneumovax:_____ Chicken Pox:_____
Shingles:_____

Name:_____ Date of birth:_____ Date:_____

Parents History: Both Healthy? Yes No

Father	Illnesses	Cause of Death	Age at Death
Mother	Illnesses	Cause of Death	Age at Death

Siblings History: Number:_____All Healthy? Yes No

1	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
2	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
3	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
4	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
5	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
6	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
7	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death
8	Brother / Sister / Half	Illnesses	Cause of Death	Age at Death

Children(s) History: Number:_____All Healthy? Yes No

1	Son / Daughter	Illnesses	Cause of Death	Age at Death
2	Son / Daughter	Illnesses	Cause of Death	Age at Death
3	Son / Daughter	Illnesses	Cause of Death	Age at Death
4	Son / Daughter	Illnesses	Cause of Death	Age at Death
5	Son / Daughter	Illnesses	Cause of Death	Age at Death
6	Son / Daughter	Illnesses	Cause of Death	Age at Death

Name:_____ Date of birth:_____ Date:_____

Social History:

Illicit Drug Use: NO YES Type:_____ Year Quit:_____

Alcohol Use: None Minimal Moderate Large Recovering Alcoholic
TYPE: Beer Wine Hard Liquor

Tobacco Use: Did you ever use tobacco products? YES NO
Cigarettes Pipe Cigar Smokeless Tobacco
Max Amt_____ Total years smoking_____ Year Quit_____

Caffeine Use: None Minimal Moderate Large

Exercise: NO YES Type:_____ Frequency:_____

Occupation:_____Currently Working Yes No

Birth Control Method:_____

Women Only: Number of Pregnancies:_____ # of Deliveries_____
Hysterectomy: Age_____ Method: Vaginal or Abdominal
Ovaries removed: YES NO
Last Pap Smear:_____ Last Mammogram:_____ Last Dexa Scan:_____

Surgical History: (please circle all that apply)

Appendix	Carpel Tunnel Release	Hip Replacement	Thyroid Surgery
Back Surgery	Cataract Surgery	Hysterectomy	Tubal Ligation
Breast Augmentation	Gallbladder	Knee Arthroscopy	Vasectomy
Breast Biopsy	Colectomy	Knee Replacement	Wisdom Teeth
Breast Reduction	D&C of Uterus	Mastectomy R or L	Prostate Biopsy
C-Section	LEEP	Kidney Surgery	Prostatectomy-Total
Coronary Bypass Surgery	Hemorrhoid Surgery	Spleen Removal	PTCA
Carotid Surgery	Hernia Repair	Tonsil and Adenoids	Other:

Date of last: Colonoscopy_____ EGD_____ Stress test_____

Pharmacy Information:

Name of Local Pharmacy_____City:_____ Phone number_____

Name of Mail order Pharmacy_____Phone number_____