FamilyPracticeAssociates
OF WESTERN KANSAS, LLC

name _____ date _____

HEALTH HISTORY (confidential)

- ☐ aids
- ☐ alcoholism/substance abuse
- ☐ anemia
- ☐ chest pain
- ☐ eating disorder
- ☐ arthritis
- ☐ asthma
- ☐ bleeding disorder
- ☐ breast lump
- ☐ chronic bronchitis
- ☐ pacemaker
- ☐ rectal bleeding
- ☐ domestic violence
- ☐ chicken pox
- ☐ diabetes
- ☐ emphysema
- ☐ epilepsy
- ☐ glaucoma
- ☐ high blood pressure
- ☐ stomach/intestinal problems
- ☐ gout
- ☐ heart disease
- ☐ hepatitis
- ☐ pneumonia
- ☐ prostate problems
- ☐ mental condition
- ☐ rheumatic fever
- ☐ stroke
- ☐ suicide attempt
- ☐ thyroid problems
- ☐ tonsilitis
- ☐ tuberculosis
- ☐ vaginal infections
- ☐ sexually transmitted disease
- ☐ abnormal mammogram
- ☐ mumps
- ☐ depression
- ☐ cancer of _____
- ☐ liver disease
- ☐ measles
- ☐ migraine headaches
- ☐ miscarriage
- ☐ hernia
- ☐ abnormal pap smear
- ☐ high cholesterol
- ☐ HIV positive
- ☐ kidney disease
- ☐ multiple sclerosis
- ☐ back pain
- ☐ other _____

DATES OF LAST

mammogram: _____ physical: _____ pap smear: _____ prostate exam: _____ colonoscopy: _____

WOMENS HEALTH

#pregnancies: _____ #deliveries: _____ #abortions: _____ #miscarriages: _____

year of deliveries: _____ gender of children: _____ last menstrual cycle: _____

SOCIAL HISTORY

ALCOHOL USE

do you drink alcohol? no: ☐ yes: ☐ #drinks/week: _____

DRUG USE

do you use any recreational drugs? ☐ how often? _____

OTHER CONCERNS

caffeine: ☐ none: ☐ coffee/tea/soda: ☐ cups/day: _____

TOBACCO USE

cigarettes: ☐ never: ☐ years of smoking: _____

packs per day: _____ quit date: _____

MARITAL STATUS

Married: ☐ Single: ☐ Divorced: ☐ Widowed: ☐

MEDICATIONS Prescription and nonprescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

medication: _____ dose: _____ how many times per day: _____
medication: _____ dose: _____ how many times per day: _____
medication: _____ dose: _____ how many times per day: _____
medication: _____ dose: _____ how many times per day: _____

ALLERGIES or reactions to medications:

_____

FAMILY HISTORY

please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

arthritis, gout: _____
asthma, hayfever: _____
cancer: breast ☐ colon ☐ (specify): _____
chemical dependency: _____
diabetes (type 1/type 2): _____
heart disease, stroke: _____
high blood pressure: _____
kidney disease: _____
tuberculosis: _____
hyperlipidemia: _____
alcoholism: _____
depression: _____
other: _____

fathers age: _____ age at death: _____ cause of death: _____
mothers age: _____ age at death: _____ cause of death: _____
brothers age: _____ age at death: _____ cause of death: _____
_____ age at death: _____ cause of death: _____
sisters age: _____ age at death: _____ cause of death: _____
_____ age at death: _____ cause of death: _____

HOSPITALIZATION/SURGERIES

year: _____ hospital: _____ reason: _____
year: _____ hospital: _____ reason: _____
year: _____ hospital: _____ reason: _____
year: _____ hospital: _____ reason: _____
year: _____ hospital: _____ reason: _____
year: _____ hospital: _____ reason: _____

have you ever had a blood transfusion? ☐ approximate dates: _____

SERIOUS ILLNESS/INJURIES

date: _____ serious illness/injuries: _____ complications: _____
date: _____ serious illness/injuries: _____ complications: _____
date: _____ serious illness/injuries: _____ complications: _____
date: _____ serious illness/injuries: _____ complications: _____
date: _____ serious illness/injuries: _____ complications: _____
date: _____ serious illness/injuries: _____ complications: _____

OCCUPATIONAL CONCERNS

if work exposed you to the following:

stress: ☐ hazardous substances: ☐ heavy lifting: ☐ others: _____
your occupation: _____

SIGNATURES

date of birth: _____

date: _____ patient/patient representative (please print) _____

date: _____ patient/patient representative (signature) _____

date: _____ reviewed by: _____