RIO FAMILY MEDICINE

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HEALTH HISTORY

Date

Name: _____ Birth Date: _____Age:_____

Social Security Number: Phone (Day): Cell: (H):

Do you have an advance medical directive? Circle one: Yes No

PAST MEDICAL HISTORY: Have you ever had any of the following illnesses?
Please circle and state **year of onset**

Alcoholism/Addiction	Colitis	Hepatitis	Pneumonia
Allergy/hay fever	Depression	High cholesterol	Prostate disease
Anemia	Diabetes	High blood pressure	Seizures
Angina/Heart Attack	Gallbladder disease	Hives/eczema	Thyroid disease
Arthritis	Glaucoma	Kidney disease	Tuberculosis
Asthma	Gout	Migraines	Ulcers
Blood transfusions	Heart problems	Osteoporosis	Urinary infections
Cancer of:		Pancreatitis	Other:

HOSPITALIZATIONS: Were you ever hospitalized for operations, illness, or injury?

Reason/Year	Reason/Year

MEDICATIONS: List current medications and dosage, including over the counter medications and supplements:

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES: Allergy to any drug_____

X-Ray Dye_____ Food _____

IMMUNIZATIONS: (date of last)

Tetanus	Pneumonia	Influenza
Chickenpox	Hepatitis A	Hepatitis B

Patient Name: _____ Date: _____

SCREENING EXAMS: (date of last)

Pap	Colonoscopy	Prostate (PSA)
Mammogram	Sigmoidoscopy	Cholesterol

SOCIAL HISTORY:

Habits: Do you smoke? Yes No Packs per day? _____

Past Smoking History Yes No Packs per day? _____When stopped? _____

Do you drink alcoholic beverages? Yes No How much? _____

(If you use illicit drugs, please speak to us in confidence.)

Do you exercise? Yes No How often? _____

Occupation: _____

Hobbies/Social activities: _____

Whom do you live with, if anyone? _____

Are you retired? _____ Are you now disabled?

_____

FAMILY HISTORY: Has any member of your family (parents, brothers, sisters,) had any of the following?
Please state who in the family. F=Father M=Mother S=Sibling

Alcoholism	F	M	S	Thyroid disease	F	M	S
Asthma	F	M	S	Cancer – Breast		M	S
Depression	F	M	S	Cancer – Colon	F	M	S
Diabetes	F	M	S	Cancer – Ovarian		M	S
Heart disease	F	M	S	Cancer – Prostate	F		S
High blood pressure	F	M	S	Cancer – Other	F	M	S
High cholesterol	F	M	S	Other Disease	F	M	S
Osteoporosis	F	M	S		F	M	S
Stroke	F	M	S		F	M	S

Please mark below:	IF LIVING		IF DECEASED	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER 1				
BROTHER 2				
SISTER 1				
SISTER 2				
SPOUSE				