FAMILY FIRST MEDICINE, APMC
MEDICAL & FAMILY HISTORY FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____ MALE/FEMALE MARITAL STATUS: S M W D SEP

LANGUAGE: _____ * DO YOU HAVE A SIGNED ADVANCED DIRECTIVE? YES or NO

FAMILY HISTORY – CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE

1) ALCOHOLISM _____
2) ALLERGIES _____
3) ANEMIA _____
4) ARTHRITIS _____
5) ASTHMA _____
6) BLEEDING DIS. _____
7) CANCER _____
8) DEPRESSION _____
9) DIABETES _____
10) EPILEPSY _____
11) GLAUCOMA _____
12) HEART DISEASE _____
13) HEPATITIS _____
14) HYPERTENSION _____
15) LIPID DIS. _____
16) MENTAL ILLNESS _____
17) MIGRAINE _____
18) OSTEOPOROSIS _____
19) STROKE _____
20) THYROID DIS. _____

ALLERGIES: _____

_____

HOSPITAL ADMISSIONS- LIST ILLNESS, CHILDBIRTH & OPERATIONS, INCLUDE YEAR

_____
_____
_____
_____
_____

MEDICATIONS – LIST ALL CURRENT MEDS

_____
_____
_____
_____
_____

MEDICAL HISTORY – MARK ALL THAT APPLY

____ALLERGIES
____ANXIETY
____ARTHRITIS
____ASTHMA
____BACK PAIN
____BED WETTING
____BLEEDING
____BLOOD IN URINE
____BONE/JT INJURY
____BRONCHITIS
____BRUISING
____CANCER
____CHEST PAIN
____CHICKEN POX
____CONCENTRATION
____CONSTIPATION
____CROHNS DIS
____DEPRESSION
____DIABETES
____DIARRHEA
____DIVERTICULOSIS
____DIZZY SPELLS
____ECZEMA
____EYE PAIN
____FAINTING
____FATIGUE
____GOUT
____HAIR LOSS
____HEARING PROB.
____HEARTBURN
____HEART MURMUR
____HEMORRHOIDS
____HEPATITIS
____HERNIA
____HERPES
____HIVES
____HOARSENESS
____HYPERTENSION
____IRREGULAR PULS
____KIDNEY STONES
____LEG PAIN
____MEASLES
____MEMORY LOSS
____MENTAL ILLNESS
____MOOD SWINGS
____MUMPS
____NAUSEA
____NOSE BLEEDS
____NUMBNESS
____PALPITATIONS
____PHOBIAS
____PNEUMONIA
____POLIO
____PROSTATE
____PSORIASIS
____RASHES
____RHEUM. FEVER
____RINGING IN EARS
____SEIZURES
____SINUS
____SHORTNESS OF BREATH
____SORE THROAT-FREQUENT
____STD
____STROKE
____SWELLING
____THOUGHTS OF SUICIDE
____THYROID DIS.
____TOBACCO USE
____TREMOR
____TUBERCULOSIS
____URINARY PROB.
____VARICOSE VEINS
____VISION PROB.
____WEIGHT CHANGE
____WHEEZING

REV. 8/2018