Roger W. Washington Family Medicine

PATIENT HEALTH HISTORY
(Confidential)
If completing form by hand, please print

Name________________________________ Today's Date______________

☐ Male ☐ Female Age________ Birthdate________________ (mm / dd / yyyy) Date of last physical examination________________

Marital status________________ Occupation________________________________

What is the reason for your visit today?________________________________

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
________Menstrual period	________Cholesterol testing	________Pneumonia vaccine	________Digital rectal exam
________Mammogram	________Colonoscopy	________Bone Density (DEXA)	________PSA (prostate blood test)
________Pap smear	________Tetanus booster		

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type________	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema/COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections

☐ Other ________________________________

ALLERGIES? *Check ☑ appropriate box below. If yes, please list all known allergies to medications or substances*

☐ No known allergies ☐ Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check ☑ appropriate boxes below and describe*

Caffeine	☐ None	☐ _______ drinks per __________	
Tobacco	☐ None	☐ _______ cigarettes per day	☐ Quit smoking around __________
Alcohol	☐ None	☐ _______ drinks per __________	
Drugs	☐ None	☐	
Diet	Describe:		
Exercise	Describe:		
Seat belts	☐ Always	☐ Never	☐ Sometimes

(Continued on back)

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications, if any

PREGNANCY HISTORY

pregnancies________ ; # living children ________

deliveries: C-sections_______ ; vaginal ________

Birth year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

Have you ever had a blood transfusion? ☐ No ☐ Yes Date(s):

FAMILY HISTORY

Fill in information about your family below:

Relation	Age, if living	Age at death	Medical conditions / cause of death
Father			
Mother			
Brothers			
Sisters			

Check ☑ if a blood relative has had any of the following:

Disease	Relationship to you
☐ Arthritis	
☐ Asthma	
☐ Cancer	
☐ Diabetes	
☐ Gout	
☐ Heart disease	
☐ High blood pressure	
☐ Kidney disease	
☐ Stroke	
☐ Other	

ADDITIONAL INFORMATION *What else do you think your doctor should know about your health?*

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature____