

WEST WICHITA FAMILY PHYSICIANS, P.A.

HEALTH HISTORY

(Confidential)

CONDITIONS Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Alcoholism /
Substance Abuse | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mental Condition | <input type="checkbox"/> Cancer of _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stomach / Intestinal
Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted
Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Abnormal
Mammogram | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Kidney Disease |
| | | | <input type="checkbox"/> Multiple Sclerosis |
| | | | <input type="checkbox"/> Other _____ |

Date of last mammogram _____

Date of last physical _____

Date of last prostate exam _____

Date of last Pap Smear _____

MEDICATIONS: List all medications you are currently taking, Prescription and Non-prescription	ALLERGIES: To medications or substances.
Pharmacy Name: _____ Phone: _____	

Name _____

Today's Date _____
(Requires update every two years minimum)

Birth Date _____

PART II

Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check () if your blood relative had any of the following:	
					Disease	Relationship to you
Father						
Mother					Arthritis, Gout	
Brothers					Asthma, Hayfever	
					Cancer	
					Chemical Dependency	
					Diabetes	
Sisters					Heart Disease, Stroke	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATION / SURGERIES			PREGNANCY HISTORY. TOTAL NUMBERS OF PREGNANCIES:		
YEAR	Hospital	Reason for Hospitalization	Year of Birth	Sex of Birth	Complication or miscarriage/abortions
Have you ever had a blood transfusion? yes no If yes, please give approximate dates _____			Date of last Menstrual period		
			HEALTH HABITS Check () which substances you use and describe how much you use:		
			Caffeine		
			Tobacco		
			Drugs/Alcohol		
			Others		

SERIOUS ILLNESS/INJURIES	DATE	COMPLICATIONS	OCCUPATIONAL CONCERNS Check () if work exposed you to the following:		
				Stress	
				Hazardous Substances	
				Heavy Lifting	
				Others	
			Your Occupation:		

Patient / Patient Representative Please Print

Date of Birth

Patient / Patient Representative Signature

Date

Reviewed By

Date