WEST WICHITA FAMILY PHYSICIANS, P.A.

HEALTH HISTORY

(Confidential)

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

- ☐ 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
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Vaginal Infections
- ☐ Sexually Transmitted Disease
- ☐ Abnormal Mammogram
- ☐ Mumps
- ☐ Depression
- ☐ Cancer of _____
- ☐ Cataracts
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Hernia
- ☐ Abnormal Pap Smear
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ 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
Father				
Mother				
Brothers				
Sisters				

Check ( ) if your blood relative had any of the following:

Disease	Relationship to you
Arthritis, Gout	
Asthma, Hayfever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATION / SURGERIES

YEAR	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? yes no
If yes, please give approximate dates _____

SERIOUS ILLNESS/INJURIES	DATE	COMPLICATIONS

PREGNANCY HISTORY.
TOTAL NUMBERS OF PREGNANCIES:

Year of Birth	Sex of Birth	Complication or miscarriage/abortions

Date of last Menstrual period

HEALTH HABITS Check ( ) which substances you use and describe how much you use:

	Caffeine	
	Tobacco	
	Drugs/Alcohol	
	Others	

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