Family Medicine of Albemarle
Patient Medical History

Date:_____

Name: _____SSN:_____MRN# _____
Last name First name MI Preferred name

Address:_____
Street City State Zip

_____
Home Phone (with area code) Cell Phone (with area code) Work Phone (with area code

In case of Emergency

Notify:_____
Name Address Relationship to

_____
Home Phone (with area code) Cell Phone (with area code) Work Phone (with area code

PERSONAL HISTORY: Please comment on all yes answers in comment section or on an additional sheet

Have You Had?	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
ADD/ADHD			Depression/Anxiety			Menstrual problems			Sinus condition		
Anemia			Diabetes (I or II)			Mononucleosis			Sleep Disturbance		
Asperger Syndrome			Disordered Eating			Orthopaedic			Stomach Disorder		
Asthma			Eye problem			Pneumonia			Strep throat, recurrent		
Back Problem			Gallbladder disease			POTS			Surgery		
Bipolar Disorder			Head injury			Pregnancy			Appendectomy		
Bronchitis, recurrent			Headache, recurrent			PTSD			Tonsillectomy		
Cancer (Type)			Heart condition/Murmur			Recent International Travel			Other		
Celiac Disease			Hepatitis			Recurrent Concussions			Thyroid disorder		
Chickenpox			High Blood Pressure			Seizures			Tuberculosis		
Counseling			HIV/AIDS			Self Harm			Urinary tract infection		
Crohn's/Ulcerative Colitis			Kidney disorder			Sexually transmitted disease			Weight gain/loss, recent		

HOSPITALIZATIONS/SURGERY: □ None

Reason(s)
_____Date(s)_____
Reason(s)
_____Date(s)_____
Reason(s)
_____Date(s)_____
Reason(s)
_____Date(s)_____

MEDICATIONS, HERBALS, MINERALS:

Name:_____Use:_____ Dose:_____
Name:_____Use:_____ Dose:_____
Name:_____Use:_____ Dose:_____
Name:_____Use:_____ Dose:_____
Name:_____Use:_____ Dose:_____

ALLERGIES: (Medications/Environment/Food)

Type	***Reaction (rash/tongue swelling etc)***

SOCIAL HISTORY:

Occupation:_____Marital Status:_____

Tobacco Use: □Never □In the Past □Presently-How much?_____

Alcohol Use: □None □Occasional_____ □Daily. How much?_____

Recreational/Street Drugs □No □Yes If so, what: _____

IMMEDIATE FAMILY MEDICAL HISTORY

	No	*Yes*	*Relationship*		*No*	*Yes*	*Relationship*
Alzheimer's				Genetic Disorder			
High Blood Pressure				Neurological Disorder			
Blood or clotting disorder				Drug/Alcohol Abuse			
Glaucoma				Diabetes			
Autoimmune disease				Heart Disease			
Cancer (Type)				Kidney Disease			
Liver Disease				Seizures			
Thyroid Problems				Stroke			
HIV				Tuberculosis			
Pneumonia				Psychiatric/mental health disease			
Arthritis				Family history of sudden death before age 50			

HEALTH MAINTENANCE

*Describe your exercise*_____

Do you wear a seatbelt? □Yes □No

Sexual Active: □yes □no with □Men □Women □both □one partner

Women: Last menstrual period_____

Please circle or check the any symptoms:

Over the past **two weeks**, how often have you been bothered by any of the follow problems?	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN ONE-HALF THE DAYS**	**NEARLY EVERY DAY**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

*****Please note that any acute or chronic issues addressed at a preventive visit may incur a copay or additional cost*****

General: □ Weight loss □ Weight gain □ Fatigue/weakness □ Fever □ Trouble sleeping □ None	**Throat:** □ Tooth/gum pain □ Sore throat □ Hoarseness □ Post nasal drip □ Stiffness □ Swollen glands □ None	**Gastrointestinal:** □ Heartburn □ Constipation □ Abdominal pain □ Hemorrhoids □ Change in appetite□ Nausea □ Vomiting □ Gas □ Change in bowel habits □ Rectal bleeding, coffee-ground stool □ Diarrhea □ None	**Skin:** □ Rashes □ Acne □ Dryness/ itching □ Color changes with cold □ Hair and nail changes □ Easy bruising □ Mass □ None
Eyes: □ Change in vision □ Glasses or contacts □ Pain/redness □ Glaucoma □ Something in eye feeling □ Last eye exam:_____ □ None	**Breasts:** □ Lumps □ Pain □ Discharge □ None	**Urinary:** □ Frequency □ Burning or pain □ Blood in urine □ None	**Neurologic:** □ Headache □ Dizziness/fainting □ Weakness □ Memory loss □ Numbness/tingling □ Loss of consciousness □ None
Ears: □ Decreased hearing □ Ringing in ears □ Earache □ Drainage □ None	**Cardiovascular:** □ Chest pain/ tightness □ Skipped heartbeat □ High blood pressure □ Heart murmur □ None	**Genital** □ Pain with sex □ Hernia □ Sexually active □ Penile discharge □ Vaginal discharge □ Itching/rash □ Sores □ Masses □ None	**Psychiatric:** □ Nervousness □ Anxiety □ Depression □ Panic attacks □ Insomnia □ Stress □ Self injury □ Thoughts of suicide □ None
Nose: □ Stuffiness □ Discharge □ Itching □ Nosebleeds □ Sinus pain □None	**Respiratory:** □ Cough □ Sputum □ Coughing up blood □ Night sweats □ Shortness of breath □ Wheezing □ Coughing up mucous □ Painful breathing □None	**Musculoskeletal:** □ Muscle pain/ weakness □ Joint pain/ stiffness □ Trauma □ Back pain □ Neck pain □ Calf pain/cramps □ None	**Endocrine:** □ Cold/ heat intolerance □ Frequent urination □ Thirst □ Menstrual cycle irregular □None