Sunshine
Family Medicine Inc.

Name:_____

Date of Birth:_____ Date_____

What medical problems do you have? Please circle.

AIDS/HIV	Cataracts	Hepatitis	Pacemaker	Thyroid Disease
Alcoholism	Chicken pox	Hernia	Pneumonia	Ulcers/Heartburn
Allergies	Diabetes	Herpes	Polio	Vaginal Infections
Anemia	Depression	High cholesterol	Psychiatric care	Venereal Disease
Asthma	Emphysema	High blood pressure	Rheumatic fever	Other:_____
Bleeding Disorder	Glaucoma	Kidney Disease	Seizures	_____
Breast Lump	Gout	Liver Disease	Stroke	_____
Bronchitis	Heart disease	Migraines	Substance abuse	_____
Cancer	Heart murmur	Miscarriage	Suicide Attempts	_____

What medical problems run in your family? Please circle.

Alcoholism	Cancer	High blood pressure	Psychiatric Care
Arthritis	Diabetes	Kidney Disease	Stroke
Asthma	Heart Disease	Liver Disease	Thyroid Disease
Bleeding disorder	High cholesterol	Migraine	Other:_____

What **surgeries** have you had?_____
_____

Have you ever been **hospitalized**?____ What for?_____
_____

Comments:_____
_____

Are you **allergic** to any medicines or foods?_____
What **medicines** or vitamins do you take?_____
_____

Have you ever had your cholesterol checked?_____ When?_____ Results_____

Are you married, single, divorced, or widowed?_____
Who lives at home with you?_____
What kind of work do you do?_____
How far did you get in school?_____

How much alcohol do you drink?_____
Do you smoke or use smokeless tobacco?____ If yes, how much?_____
Do you use marijuana, cocaine, heroin, or ecstasy? (circle)_____

Last Pap smear:_____ Last Mammogram:_____ Bone Density:_____

Colonoscopy::_____ Prostate Exam:_____

History taken/Reviewed by:_____