

Piedmont Family Practice Health History

Name: _____ Birthdate: _____ Today's Date: _____

Family History (unknown _____)

	AGE(If Living)	AGE @ TIME OF DEATH AND CAUSE OF DEATH	FAMILY HISTORY	WHO?
Father	_____	_____	Asthma	Yes No
Mother	_____	_____	Cancer	Yes No
Sibling	_____	Age Spouse	Colon Polyps	Yes No
_____	_____	Children	Depression	Yes No
_____	_____	_____	Diabetes	Yes No
_____	_____	_____	Drug/Alcohol Problems	Yes No
_____	_____	_____	Heart Disease	Yes No
_____	_____	_____	High Blood Pressure	Yes No
_____	_____	_____	Osteoporosis	Yes No
_____	_____	_____	Stroke	Yes No
_____	_____	_____	High Cholesterol	Yes No
_____	_____	_____	Migraines	Yes No
_____	_____	_____	Thyroid disease	Yes No

Social History

Place of Birth _____ Marital Status **S M W D Sep.** Habits
 Occupation _____ Past Occupations _____ Caffeine (type & amount) _____
 Highest grade completed in school _____ College _____ Post Grad _____ Tobacco (type & frequency) _____
 Hobbies _____ Veteran Yes No If used tobacco in past, date quit _____
 Exercise/Recreation _____ Alcohol (type & amount) _____

Past Medical History

Have you ever had the following? Circle "Yes" or "No" leave blank if uncertain

Blood Transfusion	Yes No	Migrane Headaches	Yes No	Kidney Disease	Yes No
Chicken Pox	Yes No	Depression/Anxiety	Yes No	Arthritis	Yes No
Pneumonia	Yes No	Alcoholism	Yes No	Back Problems	Yes No
Mononucleosis	Yes No	Drug Dependence	Yes No	Concussion	Yes No
Veneral Disease	Yes No	Diabetes	Yes No	Fractures	_____
AIDS or HIV+	Yes No	Stroke	Yes No	Cancer (type)	_____
Hepatitis	Yes No	Heart Disease	Yes No	Other	_____
Rheumatic Fever	Yes No	High Cholestrol	Yes No	_____	_____
Freq. Bladder Infect.	Yes No	Glaucoma	Yes No	_____	_____
Hay Fever	Yes No	Bleeding Tendency	Yes No	_____	_____
Asthma	Yes No	Hiatal Hernia	Yes No	Immunization Dates:	
Emphysema	Yes No	High Blood Pressure	Yes No	Tetanus Shot	_____
Thyroid Disease	Yes No	Hemorrhoids	Yes No	Hepatitis B Series	_____
Anemia	Yes No	Bowel Disease	Yes No	Pneumonia Shot	_____

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Surgeries	Hospitalizations
_____	_____
_____	_____
_____	_____

Reviewed and Updated: _____