Piedmont Family Practice
Health History

Name: ______________________ Birthdate: __________ Today's Date: __________

Family History (unknown ___)

	AGE (if living)	Name	Age @ Time of Death	Cause of Death
Father				
Mother				
Sibling				

Family History	Yes	No	Who?
Asthma	☐	☐	
Cancer	☐	☐	
Colon Polyps	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Drug/Alcohol Problems	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Osteoporosis	☐	☐	
Stroke	☐	☐	
High Cholesterol	☐	☐	
Migraines	☐	☐	
Thyroid Disease	☐	☐	

Social History

Place of Birth __________ Marital Status __________

Occupation __________ Past Occupation __________

Highest Grade Completed in School ______ College _____ Post Grad _____

Hobbies __________ Veteran Yes No

Exercise/Recreation __________

Habits

Caffeine (type & amount) __________

Tobacco (type & frequency) __________

If used tobacco in past, date quit __________

Alcohol (type & amount) __________

Past Medical History

Have you ever had the following? Check the appropriate box. Leave blank if uncertain.

	Yes	No
Blood Transfusion	☐	☐
Chicken Pox	☐	☐
Penumonia	☐	☐
Mononucleosis	☐	☐
Venereal Disease	☐	☐
AIDS or HIV+	☐	☐
Hepatitis	☐	☐
Rheumatic Fever	☐	☐
Frequent Bladder Infection	☐	☐
Hay Fever	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Thyroid Disease	☐	☐
Anemia	☐	☐

	Yes	No
Migraine Headaches	☐	☐
Depression/Anxiety	☐	☐
Alcholism	☐	☐
Drug Dependence	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
Glaucoma	☐	☐
Bleeding Tendency	☐	☐
Hiatal Hernia	☐	☐
High Blood Pressure	☐	☐
Hemorrhoids	☐	☐
Bowel Disease	☐	☐

	Yes	No
Kidney Disease	☐	☐
Arthritis	☐	☐
Back Problems	☐	☐
Concussion	☐	☐

Fractures __________

Cancer (type) __________

Other __________

Immunization Dates:

Tetanus __________

Hepatitis B Series __________

Pneumonia __________

Surgeries

____

Hospitalizations

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