BELLEVUE FAMILY PRACTICE PATIENT HISTORY FORM

Date: _____

Patient Name: _____

Personal History

Name: _____ Date of Birth ____/____/_____(mm/dd/yyyy) Age: _____

Occupation: _____

ALLERGIES: Food, Pollens, Odors, Meds, Pets etc...

Current Medications: To include Vitamins, Herbs, Supplements and Over the Counter Meds — Dose — Times/Day

Please continue on back if r

Past Medical, Surgical, & Trauma History (ie: Illness, Hospitalization, Surgery, Procedures, etc.. .) — Month / Year

Reason:

Social History: (check all that apply)

Marital Status:
___Single
___Married
___Divorced
___Widowed

Education Level:
___High School
___College
___Professional School
___Other:

Do you find your life:
___Generally Unsatisfactory/Unhappy
___Too demanding/Stressful
___Boring/Not Fulfilling
___Satisfactory

Lifestyle / Self Care Issues

Do you smoke cigarettes?	___No	___Yes	If yes, how many? ____ yrs. ____packs per day
Did you ever smoke?	___No	___Yes	If yes, when did you quit? _____
Do you drink alcohol?	___No	___Yes	If yes, how much? Type _____&_____drinks/wk
Do you drink caffeine bevarages?	___No	___Yes	If yes, which? _____
Do you use recreational drugs?	___No	___Yes	If yes, which? _____
Do you exercise regularly?	___No	___Yes	Explain: _____
Do you enjoy your job?	___No	___Yes	If no, explain: _____
Do you allow time to relax?	___No	___Yes	If no, explain: _____
Do you sleep soundly?	___No	___Yes	If no, explain: _____
Are you satisfied with your sex life?	___No	___Yes	If no, explain: _____
Are you satisfied with your social life?	___No	___Yes	If no, explain: _____
Are you satisfied with your spiritual life?	___No	___Yes	If no, explain: _____
Is your diet healthy enough?	___No	___Yes	___Not sure ____Need Help

Immunizations: Current: ____ Yes ____ No — Shingles — Pneumonia — ___ TB Test + or –

Personal and Family History

Check all that apply:

	Yourself	Mother	Father	Grandparent	Sister/Brother
AIDS					
Alcoholism					
Allergies					
Alzheimer's					
Anemia					
Arthritis					
Asthma					
Birth Defects					
Bleeding Disorder					
Breast Cancer					
Cancer					
Colon Cancer					
COPD					
Depression					
Diabetes					
Emphysema					
Epilepsy					
Glaucoma					
Heart Attack					
Heart Trouble					
High Blood Pressure					
IBS					
Kidney Disease					
Liver Disease					
Mental Illness					
Migraines					
Pneumonia					
Prostate Cancer					
Sickle Cell Anemia					
Stroke					
Suicide					
Tuberculosis					
Ulcers					
Other					

Health Screening History

List the date of your most recent test or exam:

Mammogram _____ Pap Smear _____ Breast Exam by a Dr. _____

Blood Test: Cholesterol _____ Blood Sugar _____ Other: _____

Test For Blood In the Stool: _____

Feeling the Prostate: _____ Self Exam Testicle _____ Testicle Exam by Dr. _____

Other Dr's/Specialists Seen:

_____

_____

_____

Do you have a DO NOT RESUSCITATE Status? _____ Do you have a Living Will? _____

This history record has been designed to facilitate our patients to assess their health issues in detail. This is a confidential record and will be kept in the office. Information contained here will not be relased to anyone without your authorization to do so.

Name: _____
Printed

_____
Signature

Daytime Phone: _____

Address: _____

_____