*Family Physicians of Kansas*

# Patient History

| Name: | | Date: | |
|---|---|---|---|
| Date of Birth: | | Sex: | Male Female |
| Reason for Visit: | | Age: | |
| Drug Allergies: | | Previous Physician: | |

## Medications/Herbs/Vitamins/Over the Counter/Pain Management:

| Name | Dosage | Frequency | Reason | Doctor |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## Past and Current Medical Problems:

| Problem | Date of Onset | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Surgeries/Injuries/Trauma/Medical Procedures/Colonoscopy:

| Procedure | Date | Surgeon |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## Dates of Immunizations:

Tetanus__________ Pneumonia_________ Flu_________ Shingles Dose 1 _______ Shingles Dose 2________

HPV__________ COVID-19 Dose 1 __________ COVID-19 Dose 2___________

## Symptoms:

***Circle any persistent symptoms you have had or have been treated for in the past.***

| | | | | |
|---|---|---|---|---|
| Unexplained Weight Loss/Gain | Unexplained Fatigue/Weakness | Fever/Chills | Change in Moles | Rash/Itching |
| Breast Lump/Pain/Discharge | Sore Throat/Hoarseness | Hearing Loss | Vision Changes/Eye Pain | Chest Pain |
| Irregular Heartbeat | Cough/Wheeze | Short of Breath | Heartburn | Constipation |
| Diarrhea | Increased Urination at Night | Leaking Urine | Blood in Urine | Sexual problems |
| Discharge-Vaginal/Penis | Muscle /Joint Pain | Neck Pain | Back Pain | Swollen Glands |
| Easy Bruising | Numbness/Tingling | Memory Loss | Unsteady Gait | Frequent Falls |
| Allergies/Sinus | Frequent Infections | Sleep Problems | Lack of Concentration | Depression/Stress |
| Other ______________________ | | | | |

**Adopted**: Yes or No. If yes, and you do not know your family history, **skip** this section.

| Disease: | Mother | Father | Siblings | Mom's Mom | Mom's Dad | Dad's Mom | Dad's Dad | Other Relative: | Comments |
|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | | |
| Alzheimer's | | | | | | | | | |
| Asthma | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | |
| Bleeding/clotting Prob. | | | | | | | | | |
| Cancer, Type | | | | | | | | | |
| Coronary Artery Disease | | | | | | | | | |
| Depression/Anxiety | | | | | | | | | |
| Diabetes, Type | | | | | | | | | |
| Emphysema | | | | | | | | | |
| Genetic Disorder | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| Hepatitis | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| Kidney Disease | | | | | | | | | |
| Migraines | | | | | | | | | |
| Osteoporosis | | | | | | | | | |
| Stroke | | | | | | | | | |
| Tuberculosis | | | | | | | | | |

**FAMILY HISTORY** – Place a check mark in the column to indicate which relative has had any of the following diseases.

## Social History:

Occupation:____________________________

Smoke Cigarettes: Yes No Quit Date_____

How many packs/day?__________________

Do you drink alcohol? Yes No

Do you use marijuana or recreational drugs? Yes No

Do you exercise regularly? Yes No

Marital Status: Single Married Divorced Widowed Other____________________

How many years have you smoked?_______

Other tobacco: Pipe Cigar Snuff Chew

Number of drinks/week:_________________

Number of children: Male________ Female_______

## Health Screening Tests:

Cholesterol Date:___________ Abnormal? Yes No
Colonoscopy Date:___________ Polyps? Yes No
EKG Date:___________ Abnormal? Yes No

## Women's Health History:

Total number of pregnancies: _______ Number of live births: _______ Number of miscarriages: _______ Abortions: _______

Date of Last Period:________________ Age at beginning of periods:_____ Age at Menopause:____________

Character of Periods: Light Moderate Heavy Length of Period?________ How many days between?______ Painful?__________

Last Pap:__________ Abnormal Pap?_________ Last Mammogram:___________ Breast Biopsy:_______

Birth Control Method:___________________________ Bone Density Test:_____________________________

**DNR?** Yes No **Durable Power of Attorney?** Yes No
If yes, please provide your doctor with a copy.

## Specialists you are currently seeing:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

## Other Concerns:

*Thank you for your time.*