PARKWAY FAMILY PHYSICIANS
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TODAY'S DATE_____

Label Here

NAME _____
Occupation _____
Marital Status _____

YOUR HEALTH HISTORY - Have you ever had:

____ Anemia / Sickle Cell
____ Asthma
____ Allergies
____ Birth Defects / Genetic Disease
____ Bladder Infections
____ Blood Transfusions
____ Breast Disease
____ Cancer
____ Chemical Dependency
____ Diabetes
____ Depression / Anxiety
____ Headaches
____ Heartburn
____ Heart Disease
____ Heart Murmur
____ Hepatitis / Jaundice
____ Herpes (genital / oral)
____ Does your partner have herpes? Y N
____ High Blood Pressure
____ Kidney / Urinary Problems
____ Lung Disease / TB
____ Mental Illness
____ Pelvic Disorders
____ Premenstrual Syndrome
____ Prostate Problems
____ Rheumatic Fever
____ Seizures
____ Serious accident
____ Thrombophlebitis
____ Thyroid Disease
____ Ulcers / Colitis
____ Varicose Veins
____ Vision / Hearing Problems
____ Venereal Warts
____ Other

MEDICATIONS: What drugs are you now using?

(Include vits, laxatives, aspirin, cold meds and Birth control pills)

_____
_____
_____

What drugs are you allergic to? Please describe your reaction:

_____
_____
_____
_____

HOSPITALIZATION: (Please include short-stay surgery)

Please list previous hospitalizations for surgery or illness.

DATE	TYPE OF SURGERY OR ILLNESS

PREGNANCY HISTORY

Date of birth, miscarriage, abortion, tubal pregnancy	Comments Complications

DO YOU USE ANY OF THE FOLLOWING:

(Indicate how much / how often)

Cigarettes _____
Alcohol _____
Caffeine _____

	MOM	DAD	BROTHERS	SISTERS	GRAND-PARENTS	CHILDREN	
Diabetes							
Cancer							
High Blood Pressure							
Heart Trouble							
Bleeding Problems							
Kidney Disease							
Seizures							
Birth Defects							
TB							
Emotional Problems							
Allergies							
Chemical Dependency							
Anesthesia Reaction							
Age at death (approx.)							
Other:							
Other:							

Family Tree