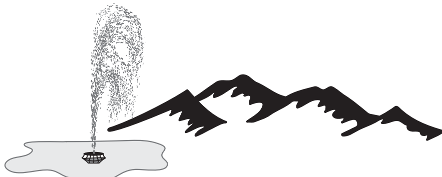

FOUNTAIN HILLS FAMILY PRACTICE, P.C.

PATIENT HISTORY

Name:	Date of Birth:	Age:	Occupation:

Have you ever had or now have problems with:

	Yes	No		Yes	No		Yes	No
Anxiety / depression			Heart Trouble			Migraines		
Asthma / emphysema			Kidney Disease			Thyroid disease		
Bleeding Tendencies			Mental Illness			Skin Issues		
Blood clots			Valley fever			Chronic back pain		
Cancer			Arthritis			Allergy Symptoms		
Diabetes			Seizures			Memory Concerns		
Glaucoma			Tuberculosis			Abnormally Tired / Fatigue		
High Blood Pressure			STD's			Chest Pain		
High Cholesterol			Stroke			Shortness of Breath		

Family History	**Age(s)**	**Medical Problems:**
Father		
Mother		
Brothers No:_______		
Sisters No:_______		

Have you ever had any operations? **Y ☐ N ☐ If yes, please list:**

Year Operation	Year Operation	Year Operation

List other illnesses not requiring an operation for which you were hospitalized:

Do you have any **allergies** or sensitivities to medicines or other substances? Y ☐ N ☐ If yes, please list with type of reaction:

Do you have any religious or cultural beliefs which may affect your care with FamilyCare? Y ☐ N ☐ If yes, please explain:

Medications, name or otherwise identify over the counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advance Directive (Living Will) in place? Y ☐ N ☐

Tobacco use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Alcohol use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Marijuana or street drug use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:

Check the diseases against which you have been immunized: Hepatitis B ☐ Hepatitis A ☐ Pneumovax ☐ MMR ☐ Tetanus ☐ Polio ☐ Diptheria ☐ Influenza ☐ Other:

Date of last Pap smear:	Date of last Mammogram:
Number of pregnancies:	Breast/Colon/Ovarian Cancer or Family History of Cancer? Y ☐ N ☐
Number of live births:	If yes, ask for Cancer Questionnaire
Are you sexually active? Y ☐ N ☐	Have you ever experienced any form of abuse? Y ☐ N ☐
Have you ever had a blood transfusion? Y ☐ N ☐	Date:

Patient Signature: Date:

Physician/Provider Signature: Date: