Medical History Today's Date: _____

Name: _____ DOB: _____ Male Female (Circle One)

Street Address: _____ City: _____ State: _____ Zip: _____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____ Ext: _____

Occupation: _____ (Circle One): Single Married Divorced Widowed Separated

If married, spouse's name: _____ ** Is your spouse your emergency contact? YES NO

Emergency Contact's Number: (_____)_____-_____ Name/Relationship: _____ **If other than spouse

Children's names and ages: _____

Do you have an Allergy to any of the following: Medications Latex Contrast/Dyes Bug Bites/Stings Foods Other (Circle all that apply)

If yes to ANY above, please list the name AND type of reaction: _____

(Circle) NKDA if you have No Know Drug Allergies _____

PAST MEDICAL HISTORY: (Please circle if you have had any problems with or experiencing any of the following):

High Blood Pressure	Persistent Cough	Unexplained weight gain/loss	Depression	Low Back Pain	Blood Disorders
Shortness of Breath	Pneumonia	Abdominal Discomfort	Anxiety	Head/Neck Pain	Hepatitis or Jaundice
Difficulty Breathing	Bronchitis	Gall Bladder Disease	Drug Abuse	Headaches	Venereal Diseases
Tightness/Pain in Chest	Tuberculosis	Constipation	Alcohol Abuse	Lightheadedness	Skin Disease
Palpitations	Indigestion	Diarrhea	Anemia	Swollen Ankles	Kidney Disease
Frequent Urination	Nausea	Colitis	Ulcers	Gout	Thyroid Disease
Rheumatic Fever	Vomiting	Blood in Stool	Hay Fever	Asthma	Change In Bowels
Cancer	Heart Disease	Hemorrhoids	Diabetes	Kidney Stones	Other:

_____

GYNECOLOGIC AND OBSTETRIC HISTORY:

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged/abnormal bleeding: NO YES (Please describe) _____

Leakage of Urine: NO YES (Please describe) _____

Pelvic Pain or abnormal discharge: NO YES (Please describe) _____

Method of birth control: _____

Please List and supply the dates of:

Operations: _____

_____

Hospitalizations other than for surgery: _____

Immunization History (have you had the following): Pneumovax? NO YES When: _____

Tetanus? NO YES When: _____

Hepatitis B? NO YES When: _____

Influenza? NO YES When: _____

I,_____ have been requested by Life Care Family Practice to supply ***my personal immunization records OR, if filling out this paperwork for a minor, the immunization records of my child. I understand that my immunization records are necessary to assist in keeping records up to date in order to receive the best medical care.

Signature_____ (Signature of patient OR legal guardian if patient is a minor)

When was your last Pap Smear: _____ Breast Exam: _____ Mammogram: _____

Cholesterol Check: _____ Prostate Exam: _____ Stool checked for blood: _____

FAMILY HISTORY: Has any member of your family ever had the following? **FIRST DEGREE ONLY** (Parents, siblings, or children)

If no one has ever had any of these problems, please indicate if parents are alive and well by checking here ☐

Illness	Which Family Member(s)	Approx. age when diagnosed
Cancer (what kind):	_____	_____
Hypertension (high blood pressure):	_____	_____
Heart Disease:	_____	_____
Diabetes:	_____	_____
Mental Disease (Anxiety, depression, etc.)	_____	_____
Drug or Alcohol Addiction:	_____	_____
Glaucoma:	_____	_____
Bleeding Disease:	_____	_____
Other:	_____	_____

MEDICATIONS (Prescription, over the counter, vitamins, herbs, etc.):

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Drug Name: _____ Strength: _____ How Often: _____

Pharmacy Name: _____ **Location**: _____ **Pharmacy Phone**: _____

PREVENTION

Have you ever smoked? NO YES If yes, how many packs per day? _____

How often do you consume alcoholic beverages? _____

Do you drink coffee or tea? NO YES If yes, how many cups per day? _____

Do you use recreational drugs? NO YES If yes, explain which one(s) & how often: _____

Do you have a living will? NO YES Do you wish to be tested for AIDS? NO YES

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? NO YES

Patient Communication Preferences

Patient Name: _____ DOB: _____

Patient confidentially is important at Life Care Family Practice. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.
In the event that I need to be reached regarding lab results, account information or for medical reasons, Life Care Family Practice may leave the information as designated:

_____ (Initials) LCFP **may not** leave Test/Lab results or account information with anyone else

_____ (Initials) Test/Lab Results

LCFP can leave my results as follows:

- May call me at _____
- May leave results on answering machine/voicemail at home number listed in chart
- May leave results on voicemail at work _____ (number)
- May leave results on voicemail on cell phone _____(number)
- May leave results with _____ (name)

_____ (Initials) Account Information

- May call me at _____
- May leave account inquiry/information on answering machine/voicemail at home
- May leave account inquiry/information on voicemail at work _____
- May leave account/inquiry/information on voicemail at home _____

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Life Care Family Practice.

My signature indicates that I understand that cell phones/cordless phones are not secured telephone lines. I also understand that my employer may monitor phone calls and/or messages I receive at work. Therefore, confidentiality is not ensured in these cases.

Patient Signature: _____ Date: _____