LAKEWOOD
FAMILY HEALTH

PATIENT NAME: _____ **DOB:** _____

REASON FOR VISIT: _____ **PROVIDER:** _____

MEDICAL HISTORY

CONDITION	Date Began		Date Began
Diabetes (Type _____)		High Blood Pressure	
Cancer (Type_____)		Stroke	
COPD		High Cholesterol	
GERD		Arthritis	
Gout		Sleep Apnea	
Asthma		Thyroid Disorder	
Allergic Rhinitis		Other	

PREVIOUS SURGERIES / MAJOR INJURIES

Type of surgery or injury	Date

PHARMACY

	Name & Address, or Cross Streets	Phone Number
Local		
Mail		

SOCIAL HISTORY

	Yes	No	#	How Often	For How Long
Alcohol	□	□		Daily Weekly Monthly Occasionally Rarely Never	
Tobacco	□	□		Daily Weekly Monthly Occasionally Rarely Never	
				Previously, but quit - Age Stopped:	
Drug Use	□	□		Daily Weekly Monthly Occasionally Rarely Never	
				Type/Frequency	

OCCUPATION: _____ **MARITAL STATUS**: _____

FAMILY HISTORY

	Age	Diseases	Living?
Father			
Mother			
Brothers #			
Sisters #			
Sons #			
Daughters #			

ALLERGIES

Medication / Dye	Type of Reaction

OB HISTORY

	Yes	No	Date of Last Cycle			Yes	No
Pregnant Now?	□	□	How Many Weeks Pregnant		Birth Control?	□	□
Infertility?	□	□	How Many Pregnancies		Abnormal Cycles?	□	□

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MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS

Drug	Dose	How Often	Reason

SPECIALISTS AND OTHER PROVIDERS

Name	Phone	Date Last Seen	Specialty

CURRENT PROBLEMS

CONSTITUTIONAL	Yes	No	**URINARY**	Yes	No
Chills	□	□	Pain on urination	□	□
Fatigue	□	□	Blood in urine	□	□
Fever	□	□	Frequent Urination	□	□
Weight Gain	□	□	**INTEGUMENTARY (SKIN)**	Yes	No
Weight Loss	□	□	Hair Loss	□	□
HEENT	Yes	No	Rash	□	□
Ear pain	□	□	**NEUROLOGICAL**	Yes	No
Eye pain	□	□	Dizziness	□	□
Sinus pressure	□	□	Extremity numbness	□	□
Sore throat	□	□	Headaches	□	□
RESPIRATORY	Yes	No	**CARDIOVASCULAR**	Yes	No
Cough	□	□	Chest Pain	□	□
Shortness of breath	□	□	Edema	□	□
Wheezing	□	□	Palpitations	□	□
PSYCHIATRIC	Yes	No	**GASTROINTESTINAL**	Yes	No
Anxiety	□	□	Diarrhea	□	□
Depression	□	□	Abdominal Pain	□	□
Insomnia	□	□	Blood in stools	□	□
MUSCULOSKELETAL	Yes	No	Constipation	□	□
Back Pain	□	□	**OTHER**	Yes	No
Joint Pain	□	□		□	□
Neck Pain	□	□		□	□

ROUTINE TESTING

Test	Date	Normal	Abnormal	Test	Date	Normal	Abnormal
Bone Density		□	□	EKG		□	□
Colonoscopy		□	□	Spirometry		□	□
Eye Exam		□	□	Stress Test		□	□
Foot Exam		□	□	PSA Blood Test		□	□
Echocardiogram		□	□	Mammogram		□	□
Endoscopy		□	□	Pap		□	□

IMMUNIZATIONS / VACCINES – Add Date

Hepatitis A		MMR		Varicella	
Hepatitis B		Pneumonia		Shingles	
HPV Vaccine		Tetanus			
Meningococcal		Tdap			