

Gleneagles Family Medicine
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To ensure I have a complete medical history, please answer the following questions. Thank you.

Who referred you to our office? _____

What are your main concerns regarding your health?

1. _____
2. _____
3. _____

What medical problems do you have? (such as high blood pressure, high cholesterol, diabetes, thyroid disease, etc.)

For women:

How many times have you been pregnant? _____ How many children have you had? _____

Did you deliver by C-section or vaginal delivery? _____

List any complications during your pregnancies or deliveries: _____

Have you ever had an abnormal Pap Smear? Yes No

List any surgeries you have had:

Surgery	Date	Surgeon
1		
2		
3		
4		
5		

To help me coordinate your medical care with all your doctors, please list any other doctors you currently see and why you see them?

1. _____
2. _____
3. _____
4. _____

Are you allergic to any of the following medications?

- | | | | |
|----------------------------|--|--|--|
| Local Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sulfa Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives or sleeping pills | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anti-inflammatory drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Iodine or betadine | <input type="checkbox"/> Yes <input type="checkbox"/> No | (like motrin, advil, ibuprofen, aleve) | |
| Coedine or other narcotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other medicines (please list): | _____ |

What medications are you currently taking? (please list prescriptions and over the counter medicines)

Medication	Dose	How many times a day?

Name _____ Date of Birth _____ Date _____

Family History (check all that apply)

	Heart Disease	Diabetes	High Cholesterol	Cancer (what type?)	High Blood Pressure	Asthma	Other (please specify)
Mother							
Father							
Children							
Brothers							
Sisters							
Aunts/Uncles							
Grandparents							

Social Habits

Do you smoke currently? _____ How much per day? _____ How many years have you smoked? _____
 Have you ever smoked? _____ How much per day? _____ How many years did you smoke? _____
 Do you drink alcohol? _____ Daily Amount?? _____ Weekly Amount? _____
 Do you use recreational drugs? Yes No

Do you consume any of the following?

Aspirin Yes No Daily Amount? _____ Weekly Amount? _____
 NSAID's Yes No Daily Amount? _____ Weekly Amount? _____
(NSAID's are non-steroidal anti-inflammatory medications like Motrin, Ibuprofen, Aleve, Advil, Goody's powder)
 Tylenol Yes No Daily Amount? _____ Weekly Amount? _____

What is your occupation? _____

Are you Single Married Divorced In a relationship Are you sexually active? Yes No

How much sun exposure do you get per day? < 30 min 30 min - 1 hr 1 - 4 hrs > 4 hrs

Do you exercise? Yes No Total time of exercise per week? _____

Do you have or have you ever had any of the following diseases or medical problems?

Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
TIA's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts / Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hiatal Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach or intestinal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart stents	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ovarian Cysts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uterine Fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent Urinary tract infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No