

GHENT FAMILY PRACTICE, Inc.

HISTORY

Name: _____ Date form filled out: ___/___/___
Occupation: _____ retired Marital Status: S M W D Educ: _____

IMMUNIZATIONS: Date of last tetanus: _____ Flu vaccine: _____ Pneumovax: _____
Varicella _____ Other: _____

PAST MEDICAL HISTORY: (Please list all significant medical diagnoses and surgeries)

YEAR:	ILLNESS / OPERATION:	YEAR:	ILLNESS / OPERATION:

MEDICATION: (name / dose / frequency) [include other-the-counter drugs (vitamins, herbals)]

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: [Please note type of reaction]

_____	_____	_____
_____	_____	_____

FAMILY HISTORY: [for all 1^o relatives: parents, grandparents, aunts and uncles, siblings, children.]

- ① Diabetes ② Hypertension ③ Stroke ④ Heart Disease ⑤ Osteoporosis ⑥ Cancer (please specify)
- ⑦ Alcohol or drug abuse ⑧ Bleeding disorder

Age of parents (indicate living or deceased):
Mother: ___ L/D Father: ___ L/D

Age of grandparents (living or deceased):
Mat. Gm: ___ L/D Mat. Gf: ___ L/D
Pat. Gm: ___ L/D Pat. Gf: ___ L/D

RISK FACTORS:

- Smoking: Never smoked I smoke: ___ cigarettes/day Quit smoking: year _____
 - Alcohol: Don't drink Drink 1 oz./day or less Drink more than 1 oz./day
 - Illicit drugs: Never used Used in past, but not last 3 yrs Have used in last 3 yrs.
 - Calcium: 2 or more milk servings every day Calcium supp Vit. D supp
 - Exercise: Never exercise Exercise <3 days/week Exercise 3 or more times weekly
- Type of exercise: _____
- Diet: I restrict salt in my diet I follow a cholesterol-lowering diet I follow a diabetic die

REVIEW OF SYMPTOMS: Check () for current problems. Mark () and indicate age when you had any of the following (Next Page):

