

NORTHWEST MEDICAL GROUP FAMILY HISTORIES

PAST HISTORY: (Mark Yes or No after each condition)

Childhood: Have you had any serious diseases in childhood? ___Yes ___No

Typhoid	___Yes ___No	Rheumatic fever	___Yes ___No	Mumps	___Yes ___No
Malaria	___Yes ___No	Scarlet fever	___Yes ___No	Skin tests for T.B	___Yes ___No
Immunizations	___Yes ___No			Valley fever	___Yes ___No

Adult Illnesses: (Mark Yes or No after each condition)

Anemia	___Yes ___No	Diabetes.	___Yes ___No	Epilepsy	___Yes ___No
Arthritis	___Yes ___No	Heart Disease	___Yes ___No	Venereal Disease	___Yes ___No
Asthma	___Yes ___No	Kidney Disease	___Yes ___No	Valley Fever	___Yes ___No
Blood Disorders	___Yes ___No	High Blood Pressure	___Yes ___No	Any Other	___Yes ___No
Cancer	___Yes ___No	Tuberculosis	___Yes ___No	(If yes, specify)	

Menstrual & Age at 1st menstrual period _____ How frequent _____

Obstetrics Periods regular _____ Number of days of flow _____

Is flow excessive _____ Date of last period _____

Bleeding between periods _____

Number of pregnancies _____ Number of live births _____

Number of children now living _____ Number of miscarriages _____

If menopausal have you had any bleeding or hot flashes _____

FAMILY HISTORY		IF LIVING		IF DECEASED	
Please fill out Health History Form					
		Age	Health	Age at Death	Cause
Father					
Mother					
Brother/Sisters*					
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
Sons/Daughters*					
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
* Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.					

PATIENT LABEL HERE

Do you know of any immediate blood relative who has or had: (Circle and give relationship)

Stroke	Epilepsy	Heart Attack	Mental Illness
Cancer	Suicide	Stomach Ulcers	Rheumatic Heart
High Blood Pressure	Migraine	Kidney Disease	Congenital Heart
Hay Fever	Goiter	Diabetes	Bleeding Tendency
Colitis	Arthritis	Tuberculosis	Leukemia
Asthma			

PERSONAL HABITS			
Yes	No	Do you regularly smoke?	Cigarettes Pipe Cigars For how many years?
Yes	No	Do you usually drink over 6 cups of coffee per day?	
Yes	No	Do you regularly drink alcohol?	1 oz per day 2 oz per day 4 oz per day over 6 oz
		BEER: 1 bottle per day 2 bottles per day over bottles per day	
Yes	No	Do you get regular exercise?	

SOCIAL HISTORY:

Birthplace: _____ Years in this area _____
 Highest grade of schooling completed _____ Religious preference _____
 Occupation: _____ Date last worked: _____
 Previous Occupations _____
 Spouse's Name _____ Spouse's Occupation: _____
 Total number of children: _____ How many children are at home: _____

DRUG ALLERGIES AND TYPE OF REACTION _____

List any hospitalizations or surgeries you have had in the past:

Operation	Year	Hospitalization	Year

List serious injuries you had:

Blood Transfusions _____ Yes _____ No If Yes, number of units _____

List all medications, including non-prescription medicines and birth control pills (give strength in mg if possible):
