Name_____Date of Birth_____Date_____

Welcome to **Masonboro Family Medicine**. Please take the time to thoughtfully fill this out as your history is very important to us to understand your health issues. Thanks

What health issues do you want to focus on during this visit? _____

_____

List any medication or food that you are allergic and have a reaction to:

_____

…if none to medication (Circle) NO KNOWN DRUG ALLERGIES

Past Medical History: List any **MAJOR** past illnesses, hospitalizations or surgeries and **date**:

_____

_____

List other Doctors/Providers you see and why:

_____

_____

Family History: Please list any known medical problems for the relatives listed below: For example diabetes, breast/colon/ovarian/prostate cancer, heart attacks. High blood pressure, alcohol abuse, depression, skin cancer, dementia, osteoporosis.

Mother_____Father_____

Brother/Sisters_____Children_____

Please outline your use of the following, past or present:

Product Tobacco	Current use yes or no?	Quantity per day	Quantity per week	Past use?	Do others have concern about your use?
Alcohol					
Recreational Drugs Caffeine/Tea					
Soda/Energy drinks					

Are you up to date on health screening and preventative services?

When have you had the following Cardiovascular stress test Eye Exam	Yes	No	Year With whom did you have it with?
Rectal Exam for Prostate Colonoscopy/Sigmoidoscopy Mammogram Pap			
Bone Density Sleep Study			

Have you had the following Immunizations?

Immunization	Yes	No	Year	
Tetanus				Booster recommended every 10 years with pertussis(whoppingcough) once as adult
Flu Vaccine				Recommended all over age of 6 mos.
Pneumonia Vaccine				Recommended once at age 65 or earlier based on health issues
Zoster (Shingles)				
Gardasil				Recommended for ages between 9 and 26

Please list your current medical problems (Diabetes, Heart Disease, Hypertension,etc)

_____

_____

Please list all prescribed and over-the-counter medication you take regularly. Please Bring all RX Medication with you.

MEDICATION and DOSE	Frequency and Time (am/pm)	What you take it for.

Use the back of the sheet to put any additional medication

List any Vitamins or Over the Counter medications you take on a regular basis:_____

_____

Do you wear a seat belt? Y N Are there guns in your home? Y N If yes are they Locked? Y N

Exercise? No Yes if Yes what and how long each time_____

How many hours of sleep do you get each night?_____ **Snore?** Y N **Have restless legs**? Y N **Use CPAP/BiPAP** ? Y N

Please Circle

Single Widowed Divorced/Separated Married In a Relationship

Who lives in your home including pets_____

Are you currently employed? If yes please indicate occupation. Retired? Caretaking? Disabled? Unemployed? List past occupation if applicable?

_____

What Pharmacy do you use so we can send Prescriptions there._____