

Capital Family Physicians, P.A.

Patient History

Patient's Name _____ Account No. _____

1. Are you allergic to any medications? _____ Which ones and what reaction occurs? _____

2. Do you use tobacco products? _____ What kind? _____ How many? _____
 If you smoked in the past, when did you quit? _____

3. Do you drink alcoholic beverages? _____ Which ones? _____
 How often do you drink them? _____

4. Date of last: Chest X-Ray _____ TB Skin Test _____ Result _____
 EKG _____ Tetanus Shot _____
 Eye Exam _____

Women Only: Last Menstrual Period _____ Pap Smear _____
 Mammogram _____

5. Past Medical Hospitalizations / Surgery:

Date	Reason

6. Family History: Please check if a blood-related family member has had any of the following:

<input type="checkbox"/> TB	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bleeding Tendency
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Strokes	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Thyroid Diseases	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Mental Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Other _____		

7. Other things about your health you wish the doctor to know: _____

8. Do you have any chronic conditions? _____

Please fill in this chart	Age (if living)	Age at Death	State of Health / Details	Cause of Death
Mother				
Father				
Brother (s) How Many?				
Alive _____ Dead _____				
Sister (s) How Many?				
Alive _____ Dead _____				
Children How Many?				
Alive _____ Dead _____				