AIFP
Associates in Family Practice, P.A.

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Adult Patient Health History

Patient Name:_____ DOB: _____

Allergies: _____

Medical History

Current Medications (include over the counter medications): _____
_____

Past Surgeries: _____
_____

Hospitalizations: _____
_____

Social History

Height: ____ft. ____ in. Weight: _____lbs. Recent weight gain/loss ____yes ____no _____amount?

Do you drink alcohol? ____Never ____Rarely ____Socially ____Moderate ____Heavy ____Recovering Alcoholic

Do you smoke? ____Never ____Current if yes, amount: _____ If a former smoker, quit when?_____

Do you have an exercise program? ____yes ____no If yes, how frequently do you exercise?: _____

Preventative Health

When was your last cholesterol screening? _____ Your last diabetes screening? _____

Date of your last Tetanus immunization? _____ Date of your last TB screening? _____

Do you have an advance directive/living will? _____

OB/GYN History

Are you pregnant now? ____yes ____no Have you ever been pregnant? ____yes ____no

# of pregnancies: _____ # of abortions: _____ # of miscarriages: ____ Are you using birth control? ___yes ____no

Date of most recent pap smear? _____ Date of most recent mammogram? _____

Family History

Please check all that apply for yourself **(Y)** and for family members **(F)**

Y/F	Y/F	Y/F	Y/F
☐☐ Chest pain	☐☐ Emphysema	☐☐ Psoriasis	☐☐ Chicken pox
☐☐ Heart murmur	☐☐ Kidney disease	☐☐ Hearing loss	☐☐ Measles
☐☐ Heart attack	☐☐ Kidney stones	☐☐ Cataracts	☐☐ Mumps
☐☐ Heart disease	☐☐ Incontinence	☐☐ Depression	☐☐ Rubella (German measles)
☐☐ Pacemaker	☐☐ Prostate disease	☐☐ Bipolar disorder	☐☐ Stomach ulcer
☐☐ High blood pressure	☐☐ Stroke	☐☐ Arthritis	☐☐ Ulcerative colitis
☐☐ Diabetes	☐☐ TIA	☐☐ Thyroid disease	☐☐ Crohn's disease
☐☐ Asthma	☐☐ Seizure	☐☐ Cancer	☐☐ Reflux
☐☐ Chronic bronchitis	☐☐ Multiple sclerosis	☐☐ Sickle cell disease	☐☐ Hepatitis
☐☐ COPD	☐☐ Parkinson's disease	☐☐ Anemia	☐☐ Hemophillia
			Other_____

Patient signature: _____ Date: _____