WACO FAMILY MEDICINE

Patient Name _____Today's Date _____

Age _____ Date of Birth _____ MRN (office use only) _____

Reason for today's visit _____

Last Primary Care Physician, location and date last seen _____

- ☐ Diabetes- Type I or II? _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Failure/CHF
- ☐ Heart Attack/Coronary Artery Disease
- ☐ Pacemaker/Defibrillator
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Asthma
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Cancer- *what type?* _____
- ☐ Thyroid problems
- ☐ Peripheral Vascular Disease/Circulation problems
- ☐ Blood Clot/DVT
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Tuberculosis
- ☐ OTHER _____

- ☐ Hepatitis- *what type?* _____
- ☐ Cirrhosis/ liver disease
- ☐ Alcoholism/Drug addiction
- ☐ Arthritis- *what type?* _____
- ☐ Gout
- ☐ Osteoporosis/Thin bones
- ☐ Prostate Problem
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Other STD/Venereal Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide attempt
- ☐ Other Mental Illness
- ☐ Seizures
- ☐ Paralysis
- ☐ Migraines

Women ONLY

When was your last PAP smear? _____

Ever had an abnormal PAP? ☐ No ☐ YES *when?* _____

FIRST day of last menstrual period? _____

When was your last mammogram? _____ _____

Ever had an abnormal mammogram? ☐ No ☐ YES

Are you currently pregnant? ☐ No ☐ YES, *Due date?* _____

Ever had complications during a pregnancy? ☐ No ☐ YES

How Many?

- ☐ Total pregnancies
- ☐ Live Births
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions
- ☐ C-Sections
- ☐ Vaginal Birth after C-section

List Allergies to medications

List current **Medications and Dose** you are taking (ex. Prinivil 40 mg daily)

Previous Surgeries	
Date(s)	
	Gallbladder
	Appendix
	Tonsils
	Hernia
	Hysterectomy- ovaries removed?
	Tubal Ligation ("Tubes tied')
	Breast biopsy
	Back surgery
	Other
	Other

Health Habits	
How much of each do you use per day? *(If not every day, how much per week?)*	
	Caffeine
	Alcohol
	Tobacco
	Street Drugs

Occupation / Travel	
Any exposure to hazardous materials?	☐ No ☐YES
Travel to Foreign Countries	☐ No ☐ YES

Family History	Check family members with the following conditions **(NOT YOURSELF)**									
	Mother	Father	Sister	Brother	Son	Daughter	MGF	MGM	PGF	PGM
Status: A= Alive or D=Descd										
Diabetes										
High Blood Pressure										
High Cholesterol										
Heart attacks										
Kidney Disease										
Bleeding problem										
Strokes										
Cancer *(what kind?)*										
Arthritis										
Asthma										
COPD/lung problems										
Psychiatric Illness										
Alcohol/Drug Abuse										
Other										

Symptoms: *Please check if you are experiencing any of the following:*

☐ Unintentional weight loss	☐ Diarrhea or Vomiting	☐ Blood in stools or urine
☐ Leaking urine or stool	☐ Night sweats/Fevers	☐ Penile or Vaginal Discharge
☐ Shortness of Breath	☐ Swelling in feet/ankles	☐ Irregular/Painful periods
☐ Che st Pain	☐ Rash	☐ Erection Problems
☐ Vision Problems	☐ Too thirsty	☐ Constipation
☐ Persistent Cough	☐ Suspicious lumps or bumps	☐ Difficulty breathing when lying down
☐ Fainting	☐ Forgetfulness	☐ New headache
☐ Trouble sleeping	☐ Pain- *where?* _____	☐ Other