

# Totem Lake Family Medicine

## Basic History Age 18 and Over

NAME \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Current Health Summary

Please bring this form with you for your exam on: \_\_\_\_\_

What is your reason for a health exam at this time? \_\_\_\_\_

**Health Habits, Life Changes:** Yes No **In the last year have you experienced any of the following:**

Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
How many cigarettes per day? _____			Marriage?	<input type="checkbox"/>	<input type="checkbox"/>
How long have you smoked? _____			Divorce or separation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Major illness or death in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever:			Personal illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
Felt the need to cut down on drinking?	<input type="checkbox"/>	<input type="checkbox"/>	Gain of new family member?	<input type="checkbox"/>	<input type="checkbox"/>
Felt annoyed by criticism of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	Change in job or home?	<input type="checkbox"/>	<input type="checkbox"/>
Had guilty feelings about drinking?	<input type="checkbox"/>	<input type="checkbox"/>			
Taken a morning eye opener?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you use seatbelts?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Work Exposure:</b>		
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Are you or were you exposed to hazards at home, at work		
What type of exercise? _____	<input type="checkbox"/>	<input type="checkbox"/>	or due to your hobbies? (e.g. biological hazards, asbestos,		
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>	chemicals, solvents, dust, fumes, heavy metals (e.g. lead		
Do you need help with household chores or shopping?	<input type="checkbox"/>	<input type="checkbox"/>	or mercury), excessive noise, radiation, high stress or		
			extremes of temperature). Which ones? _____		

### **Body Systems Review:**

	Yes	No	Uncertain
1. How would you describe your health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
2. Do you tire easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you lost 10 pounds or more without trying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you noticed any major changes in your skin (moles, rashes, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have trouble with your eyes or ears (other than a need for glasses)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you short of breath, hoarse, or prone to wheezing or coughing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have chest pain with activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are your feet or ankles often swollen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble swallowing, heartburn, stomach pain or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you noticed blood or any recent change in your bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have any sexual problems you wish to discuss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you or your partner had problems with child bearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have difficulty urinating or holding your urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a back, joint or muscle problem that interferes with work or life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you often have a problem with severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### **Women Only**

1. Do you have breast lumps, lumps in your armpit, or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had an abnormal pap smear? _____ How long ago? _____			

### **Chief Complaints:**

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**Physician Comments:** \_\_\_\_\_

**Adult Health Questionnaire- Basic Health History Age 18 and Over (cont.)**

**Personal Health:**

Have you had any of the following:	Yes	No		Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (jaundice)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments to head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mother received hormones (DES) for threatened miscarriage when pregnant with you	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Other illness (please describe) _____		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>	_____		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**Women only:**

Do you do a monthly breast exam? \_\_\_\_\_

Number of times pregnant \_\_\_\_\_

Number of living children \_\_\_\_\_

Do you have periods? \_\_\_\_\_

Frequency of periods? \_\_\_\_\_

Last menstrual period? \_\_\_\_\_

**Immunizations:**

	Yes	No
Have you had a tetanus booster in the past ten years?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumovax in the past years?	<input type="checkbox"/>	<input type="checkbox"/>

**Advanced Directives:**

Do you currently have a living will?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you interested in establishing a living will?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**Family Health:**

Is your mother living?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age now or at death: Mother _____ Father _____
Is your father living?	<input type="checkbox"/>	<input type="checkbox"/>	How many brothers do you have? _____
			How many sisters do you have? _____

**Illness in Family:**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers or Sisters: \_\_\_\_\_

Has any family member had:	Yes	No	Who
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name any conditions that run in your family: \_\_\_\_\_

\_\_\_\_\_

**Marital status:** (check one)    Single     Married     Widowed     Domestic Partner

Adult Health Questionnaire- Basic Health History Age 18 and Over (cont.)

This questionnaire will become a CONFIDENTIAL AND PRIVATE part of your medical record as provided by law. We encourage you to fill out the entire form. If you do not want to answer a question, leave it blank.

IDENTIFICATION

Address \_\_\_\_\_

Phone \_\_\_\_\_

1. Current Occupation \_\_\_\_\_

2. Usual Occupation (kind of work done during most of life even if retired): \_\_\_\_\_

3. Kind of business or industry \_\_\_\_\_

Employer \_\_\_\_\_

4. Briefly describe what you do at work: \_\_\_\_\_

5. What are your hobbies or interests outside work? \_\_\_\_\_

In Case of Emergency Notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

History:

Past Medical History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications:

Drug or Medication	Dosage	For What Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Form of birth control:

\_\_\_\_\_  
Please list any non-prescription medications you take (for example - aspirin, laxative, Geritol, vitamins, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any drug or medications    yes     no

If yes, name drug and describe reason:  
\_\_\_\_\_  
\_\_\_\_\_