

# HEALTH HISTORY

(Family Care Center – Bay / Marianna)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

CONDITIONS			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer			<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts			<input type="checkbox"/> Venereal Disease

**Who was your primary care physician?** \_\_\_\_\_

**What are your allergies to medications?** \_\_\_\_\_

**What are your other allergies?** \_\_\_\_\_

FAMILY HISTORY						
Relation	Age	State of Health	Age at Death	Cause of Death	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS/SURGERIES				PREGNANCY HISTORY/MISCARRIAGES		
Year	Hospital	Reason for Hospitalization and Outcome		DOB/SEX	COMPLICATIONS	YR MISCARRIAGE
				/		
				/		
				/		

**TODAY'S SYMPTOMS/PROBLEMS**

\_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate date(s) \_\_\_\_\_

HEART CONDITIONS			OCCUPATIONAL/PERSONAL		
YEAR	HOSPITAL	REASON FOR HOSPITALIZATION AND OUTCOME		Stress	
				Hazardous Substances	
				Heavy Lifting	
				Tobacco/Caffeine	
				Other	

**BIRTH/DEVELOPMENTAL HISTORY** \_\_\_\_\_ **DOMESTIC VIOLENCE:** \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold Horacio J Rodriguez-Jimenez, MD, Bay Family Care Center and/or any members of its staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
 Patients Signature Date

\_\_\_\_\_  
 Reviewed By Date

