FamilyMedix Primary Care Clinic, 713-715-1234

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Medications

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

PAST MEDICAL HISTORY: Please mark all that apply:

Anxiety Disorder	Diabetes - Insulin	Reflux or Ulcers	Osteoporosis
Arthritis	Diabetes - Non-Insulin	HIV or AIDS	Polio
Asthma	Dialysis	High Cholesterol	Pulmonary Embolism
Bleeding Disorder	Diverticulitis	High Blood Pressure	Tuberculosis
Blood Clots (or DVT)	Fibromyalgia	Kidney Disease	Thyroid disease
Cancer	Gout	Kidney Stones	Stroke
Coronary Artery Disease	Has Pacemaker	Leg/Foot Ulcers	Other:
Claustrophobic	Heart Attack	Liver Disease	

IMMUNIZATION HISTORY: Please mark all that apply

Covid19 type/dates	1st dose	2nd dose	3rd dose	4th dose

Chickenpox	Hepatitis A	MMR (Measles, Mumps, Rubella)	Tdap (Tetanus and pertussis)
Flu Shot	Hepatitis B	Meningococcus	Tetanus
Gardasil/HPV	Zostavax (Shingles)	Pneumonia	

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

FAMILY HEALTH HISTORY:

Father:	Mother:
Brother:	Sister:
Grandmother:	Grandfather:

Social History

What is your relationship status: Married Single other			Have you recently traveled abroad:	Yes	No
How many children do you have:			In the 14 days, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill:	Yes	No
Are you able to care for yourself:	Yes	No	In the 14 days, have you had close contact with a person who is under investigation for COVID-19 while that person was ill:	Yes	No
Are you blind or do you have difficulty seeing:	Yes	No	What type of diet are you following: Regular Vegetarian Other		
Are you deaf or do you have serious difficulty hearing?	Yes	No	Do you have any dietary restrictions:	Yes	No
Any difficulty concentrating or remembering?	Yes	No	What is your exercise level: Occasional Moderate Heavy		
Do you have difficulty walking or climbing stairs:	Yes	No	Do you or have you ever smoked tobacco:	Yes	No
Do you have difficulty dressing or bathing:	Yes	No	What was the date of your most recent tobacco screening:		
Do you have difficulty doing errands alone:	Yes	No	Level of alcohol consumption: Occasional Moderate Heavy		
Are you able to walk:	Yes	No	Do you use any illicit or recreational drugs:	Yes	No
Do you have transportation difficulties:	Yes	No	Have there been any changes to your family or social situation:	Yes	No

(WOMEN ONLY) OBSETRIC & GYNECOLOGICAL HISTORY

Last PAP Smear Date:	Last Mammogram Date:
Number of pregnancies:	Do you use birth control: Yes No (What Method:_______________)

Please mark All that apply

Bleeding between periods	Vaginal itching, burning, or discharge	Breast lump or nipple discharge
Heavy periods	Wake in the night to go to the bathroom	Painful intercourse
Extreme menstrual pain	Hot flashes	Sexually active: Yes No

Patient First and Last name: **Patient's Signature** **Date**