DR. RUSSELL W. FARIA, DO, PC
FAMILY PRACTICE

PATIENT & FAMILY HEALTH HISTORY

PATIENT NAME ____________________ **TODAY'S DATE** __________

DATE OF BIRTH __________ **SSN** __________

CHIEF COMPLAINT: (list in order of importance, your present health concerns, symptoms or problems you are experiencing)

1) ____________________
2) ____________________
3) ____________________
4) ____________________

PATIENT MEDICAL HISTORY

Mark Yes or No or leave blank if uncertain	YES	NO
Allergies, asthma, hay fever		
Anemia		
Alcoholism		
Arthritis		
Back trouble		
Bleeding problems		
Bladder Infection		
Birth Defects		
Cancer		
Diabetes		
Depression		
Emphysema		
Epilepsy or seizures		
Glaucoma		
Gallstones		
Heart trouble		
High blood pressure		
Kidney disease		
Mental illness		
Migraine headaches		
Osteoporosis		
Rheumatic fever		
Stroke		
Thyroid disease/ goiter		
Tuberculosis		
Ulcers		
Venereal disease		

FAMILY MEDICAL HISTORY

Mark Family Member(s) or leave blank if uncertain	FATHER	MOTHER	SIBLING	G.PARENT
Allergies, asthma, hay fever				
Anemia				
Alcoholism				
Arthritis				
Back trouble				
Bleeding problems				
Bladder Infection				
Birth Defects				
Cancer				
Diabetes				
Depression				
Emphysema				
Epilepsy or seizures				
Glaucoma				
Gallstones				
Heart trouble				
High blood pressure				
Kidney disease				
Mental illness				
Migraine headaches				
Osteoporosis				
Rheumatic fever				
Stroke				
Thyroid disease/ goiter				
Tuberculosis				
Ulcers				
Venereal disease				

PATIENT SOCIAL HISTORY

Please check off appropriate box for each area.

MARITAL STATUS
☐ Single ☐ Married ☐ Divorced ☐ Widowed

USE OF ALCOHOL
☐ Never ☐ Rarely ☐ Moderate ☐ Daily

USE OF TOBACCO
☐ Never
☐ Quit as of: __________
☐ Current: Packs/Day __________

USE OF DRUGS
☐ Never
☐ Type/Frequency __________

EXPOSURE AT HOME OR WORK TO:
☐ Fumes ☐ Dust
☐ Solvents ☐ Noise
☐ Airborne partials

ALLERGIES: Please list type and Reaction

Name of Drug/ Item/Food	Reaction

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING
(include nonprescription drugs)

LIST ALL SERIOUS ILLNESSES/INJURIES

SURGICAL HISTORY	DATE

TEST AND IMMUNIZATIONS	Never	Not Sure	Yes	Year Done	Notes/Complications
Blood Profile					
CBC					
Chest X-Ray					
Cholestreol, Triglycerides					
Complete Physical					
EKG					
Fasting Blood Sugar					
Flu Shot					
Hearing Test					
HIV Test					
Pneumonia Vaccine					
Stool Occult Blood					
Tetanus (DPT)					
Urinalysis					
Vision Test					
Other					

WOMEN ONLY:

OB/GYN HISTORY	YES	NO	DATE/NO.
Are your menses regular?			
Do you experience:			
Spotting between periods?			
Pain/Cramps?			
Any itching in vaginal area?			
Pain with intercourse?			
Are you sexually active?			
Are you using contraception?			
Type:			
No. of days between periods			
No. of days periods last			
Date of last menstrual period			
Date of last pelvic exam			
Date of last Pap smear			
Was it normal?			
Date of last mammogram			
No. of pregnancies			
No. of full term births			

MEN ONLY:

	YES	NO	DATE
Discharge from penis?			
Pain or lump in testicles?			
Impotence?			
Are you sexually active?			
Are you using contraception?			
Date of last physical exam:			

Notes:

Please note any other concerns you wish to discuss with the doctor