



Charlottesville Family Medicine

3025 Berkmar Drive, Suite 1 Charlottesville, Virginia 22901 434-973-1831

Chart No. _____

Date: _____

Day Phone: _____

HEALTH HISTORY

Name _____ Date of Birth _____

Current Medical Problems or other concerns

1 _____

2 _____

3 _____

4 _____

PAST MEDICAL HISTORY (Check those you have had)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Allergies / hayfever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Arthritis / gout |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Hepatitis / liver disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma / bronchitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Intestinal disorder | <input type="checkbox"/> Sexually trans. disease |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Menstrual disorder | <input type="checkbox"/> Depression |

DRUG ALLERGIES

1 _____

2 _____

3 _____

4 _____

None

HOSPITALIZATIONS OR SURGERIES (reason / date)

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

CURRENT MEDICATIONS (name / dose) / SUPPLEMENTS

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

IMMUNIZATIONS (date of last)

Tetanus _____ Gardasil _____
Influenza _____ Hepatitis B _____ A _____
Pneumovax _____

SCREENING EXAMS (date of last)

Pap _____ Mammogram _____
Fecal Blood _____ Prostate _____
Sigmoidoscopy _____ Lipids _____

FAMILY HISTORY (Father, Mother, Siblings, Grandparents)

ADVANCE MEDICAL DIRECTIVE

Do you have an advance directive? Yes No

If yes, do you have: Living Will
 Health Proxy

Are you an organ donor? Yes No

Are you interested in information? Organ Donation
 Advance Directive

SOCIAL HISTORY

Marital Status S M D W Live Alone Other
Occupation _____ Exercise (#days/wk, type) _____ Alcohol use (#drinks/wk) _____
Hobbies / Social _____ Special Diet? _____ Tobacco use (#packs/day) _____
Caffeine use (#cups/day) _____
Other drugs/herbs/vitamins _____

DETAILED REVIEW OF SYSTEMS: Please check any signs or symptoms that are present now or have been in the past few weeks. Also note those recurrent symptoms that are concern to you even if not active at the present time.

1 CONSTITUTIONAL

- Fatigue
- Lack of energy
- Weight loss or gain (_____ lbs.)
- Loss of appetite
- Difficulty sleeping
- Night sweats

2 Skin

- Rashes
- Moles
- Change in hair color
- Change in hair texture
- Change in hair distribution
- Change in nails

3 Blood

- Bruise easily
- Low blood
- Bleed easily
- Enlarged glands (lymph nodes)

4 Head

- Headache (not frequency, intensity, duration, and causative factors) _____

5 Ears

- Ringing in ears
- Difficulty hearing
- Excessive wax

6 Eyes

- Problems with color vision
- Difficulty reading
- Pain in eyes
- Decreased night vision
- Use glasses

Name of eye doctor _____
Date last seen _____

7 Nose

- Nosebleeds
- Deviated septum
- Chronic nasal drainage
- Sinus infection
- Sinus congestion
- Frequent sore throat

8 Teeth

- Cavities
- Regular dental care
Name of dentist _____
- Bleeding gums
- Bad breath
- Sores in mouth

9 Breast

- Lumps
- Tenderness
- Discharge
- Regular breast exam

10 Respiratory

- Cough
- Sputum
- Wheezes
- Difficulty breathing
- Asthma

11 Cardiovascular

- Chest pain
- Shortness of breath on exertion
- Excess sweating
- Irregularities of heart beat
- Shortness of breath on lying down
- Swelling of ankles
- Pain in legs while walking

12 Gastrointestinal

- Change in appetite
- Fatty food intolerance
- Indigestion
- Gall bladder disease
- Constipation
- Diarrhea
- Change in bowel habits
- Abdominal pain
- Dark, tarry stools
- Hemorrhoids
- Number of meals per day
- Number of snacks per day

13 Nervous System

- Difficulty with speech
- Difficulty with walking
- Numbness
- Weakness
- Tingling
- Seizures
- Paralysis

14 Endocrine System

- Prefer the cold
- Prefer the heat
- Excessive thirstiness
- Frequent urination

15 Urinary

- Difficulty with urinations
- Burning
- Pain
- Blood in urine

- Incontinence
- Kidney stones
Get up _____ times per night
- Back pain

16 For Men

- Swelling of testicle(s)
- Pain
- Discharge
- Difficulty with sex
- STD

17 For Women

- _____ Age at onset of period
- _____ Age of stopping periods
- _____ Frequency of periods (days)
- Cramps
- Discharge
- Vaginal itching
- Use of contraceptives
(types: _____)
- Desire to prevent pregnancy
_____ Number of pregnancies
_____ Number of children
- STD
- Difficulty with sex

18 Musculoskeletal

- Joint pain (specify: _____)
- Joint swelling (specify: _____)
- Back pain
- Stiffness

19 Miscellaneous

- Loss of appetite
- Crying spells
- Bad dreams
- Any marital or sexual problems that you would like to discuss?

20 Major events in the past year: Have you had any of the following occur to you?

- New job
- Lost job
- Moved household
- Married
- Divorce or separation
- Death of friend or loved one

21 Habits: Do you use

- Tobacco
- Alcohol
- Drugs