FLINT RIVER FAMILY MEDICINE, P.C.

Name: _____ Date: _____

Main Reason for Today's Visit: _____

PERSONAL Past Medical History: (Indicate approximate year of diagnosis, and include important details below)

_____ Migraines	_____ High Cholesterol	_____ Arthritis
_____ Stroke	_____ Asthma/COPD	_____ Blood Disorder (explain)
_____ Eye Problems (explain)	_____ Liver Disease (explain)	_____ Skin Disorder (explain)
_____ Allergies (seasonal)	_____ Kidney Disease (explain)	_____ Anxiety/Depression
_____ Heart Disease (explain)	_____ Diabetes	_____ Cancer
_____ High Blood Pressure	_____ Thyroid Disease (explain)	_____ Trauma
_____ Acid Reflux	_____	_____

(Explanation/Other) _____

_____

_____

Past Surgical History: (Surgery/Year/Dr. or Hospital)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Do you Currently Smoke Cigarettes, Cigars, Pipe, or us smokeless tobacco? YES NO Have you ever? YES NO

If Yes, How much (ex. packs/day) _____? For how many years _____?

Do you drink alcohol? YES NO If yes, how many drinks per WEEK? 0-2 3-7 8-14 15+

Have you been Hospitalized in the last year? If Yes, Explain: _____

_____

FAMILY Medical History: List only first or second degree relatives (Indicate which family member for each with abbreviations)

F=Father, M=Mother, B=Brother, S=Sister, PGF=Paternal Grandfather, MGM=Maternal Grandmother, A=Aunt, U=Uncle, C=Child

_____ Migraines	_____ High Cholesterol	_____ Arthritis
_____ Stroke	_____ Asthma/COPD	_____ Blood Disorder
_____ Eye Problems (explain)	_____ Liver Disease	_____ Skin Disorder
_____ Allergies (seasonal)	_____ Kidney Disease	_____ Anxiety/Depression
_____ Heart Disease (explain)	_____ Diabetes	_____ Cancer
_____ High Blood Pressure	_____ Thyroid Disease	_____ Trauma

(Explanation/Other) _____

_____

Allergies: (List Specific Medication, Drug, or Food/Year of Last Event/Type of Reaction)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: Complete below or provide a separate list (Med/Year Started/Recent Prescribing Physician)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems: Please CIRCLE only if you are currently or recently had these symptoms, or they tend to recur often

Constitutional: Fever, Chills, Night Sweats, Unintentional Weight Loss

Eyes: Blurry Vision, Blind Spots in Vision

ENT: Runny Nose, Sinus Congestion, Sore Throat, Difficulty Swallowing

CV: Chest Pain, Racing Heart Beat, Lightheadedness, Leg Swelling, Short of Breath when Lay Flat,

Resp: Shortness of Breath (at rest of with minimal exertion), Chronic Cough (> 3 weeks), Coughing Blood

GI: Heartburn, Abdominal Pain, Change in stool size or color, Blood in Stool

GU: Pain or Burning with Urination, Urinating More Often, Loss of Control, Weak Stream, Blood in Urine

MSK: Recent trauma, Muscle aches, Joint/Bone Pain, Muscle Twitching

Neuro: Numbness/Tingling, Weakness, Change in Gait, Dizziness

Skin: Rash, Ulcer, Non Healing Wound, New Lumps or Bumps, New or Changing Moles

Endocrine: Fatigue, Hair Loss, Dry Skin, Drinking more than normal, Urinating more than normal

Heme/Lymph: Easy Bruising, Nosebleeds, Enlarged Lymph Nodes

Allergy/Immune: Lip Swelling, Throat Closing Up, Recurrent Illnesses

Psych: Feeling Tearful, Anxious, Depressed, Seeing or Hearing things that are not there

Health Maintenance: Please indicate when (if) you received the following Screening Tests

General
Colonoscopy: _____
Tetanus: _____

Smoking Hx
Abd US: _____
Chest CT: _____

Male
PSA:_____
Prostate Exam: _____

DM
Hep B: _____
A1C: _____
Eye exam: _____

Female
PAP: _____
Mammogram: _____

50, 65+
Shingles: _____
Pneumovax: _____
Prevnar 13: _____