Acacia
Family Medical Group

PATIENT HISTORY RECORD

NAME _____ DOB _____
RACE _____ ETHNICITY _____

ALLERGIES ☐ None (please list allergies and what happens to you when you take it)
Drug Allergies: _____ Food Allergies: _____
_____ _____
_____ Other Allergies:_____

CURRENT MEDICATIONS ☐ None ☐ Listed Below ☐ See copy of list attached
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY: (please check all that apply)

☐ Allergies
☐ Anticoagulant Therapy
☐ Asthma
☐ Blood Clots
☐ Cancer, _____
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes, Type I or II
☐ Enlarged Prostate, Benign
☐ Fracture repair, _____
☐ Fibromyalgia
☐ Gall Stones
☐ GERD
☐ Headaches, migraine/tension
☐ Heart Attack
☐ Hemophilia, A or B
☐ High Cholesterol
☐ High Blood Pressure
☐ Iron Deficiency Anemia
☐ Irregular Heart Rhythm
☐ Kidney Stones
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Psychological Illnesses
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease
☐ UTI, recurring
☐ Other: _____
_____
_____

WOMEN'S HEALTH: Women Only (please check all that apply)

☐ Menopause, age at _____
☐ No. of pregnancies _____
☐ No. of births _____
☐ Last Mammogram _____
☐ Last Pap _____
☐ History of Abnormal Pap _____
☐ Birth Control Method _____
☐ Last Menstrual Period _____
☐ Age Onset _____

ADULT IMMUNIZATIONS: (check if you have had and fill in Last Given date)

☐ Influenza _____
☐ HepA _____
☐ Hep B _____
☐ MMR _____
☐ Pneumococcal _____
☐ Shingles _____
☐ Tetanus _____
☐ Varicella _____
☐ Other _____

PAST HOSPITALIZATIONS: (Please indicate date)

☐ Asthma
☐ Childbirth
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ DVT
☐ Diabetes
☐ Heart Attack
☐ Pneumonia
☐ Stroke
☐ Other: _____
_____

OTHER DOCTORS: (Please list all of your Physicians, optometrist, podiatrist, etc)
Primary Care Doctor: _____
Others (specialists): _____

ADVANCED DIRECTIVES: Do you have any of the following on file?
☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney ☐ DNR

SURGICAL HISTORY: (Please indicate date & details)

☐ Appendectomy
☐ Arthroscopy, _____
☐ Biopsy, _____
☐ Carpal Tunnel Release
☐ Cataract Removal
☐ Circumcision
☐ C-section
☐ D & C
☐ Fracture Repair, _____
☐ Gall Bladder Removal
☐ Heart Surgery, _____
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Replacement, _____
☐ Tubes in Ears
☐ Prostatectomy
☐ Rotator Cuff Repair
☐ Tonsil/Adenoidectomy
☐ Tubal Ligation
☐ Urinary Surgery, _____
☐ Vasectomy
☐ Other: _____
_____
_____

FAMILY HISTORY:
(Indicate which family member: M=mother; F=father; S=sibling; C=child; GM=grandmother; GF=grandfather)

☐ Alcoholism:
☐ Alzheimer's Disease:
☐ Asthma:
☐ Bleeding Tendency:
☐ Cancer, _____
☐ Chemical Dependency:
☐ COPD:
☐ Coronary Artery Disease:
☐ Diabetes, Type I or II:
☐ Enlarged Prostate:
☐ Emphysema:
☐ Gall Stones, recurring:
☐ Heart Attack:
☐ Heart Disease:
☐ High Blood Pressure:
☐ High Cholesterol:
☐ Kidney Disease:
☐ Obesity:
☐ Osteoarthritis:
☐ Osteoporosis:
☐ Psychiatric Illness, _____
☐ Rheumatoid Arthritis:
☐ Seizure Disorder:
☐ Stroke:
☐ Thyroid Disease:
☐ Other: _____
_____

SOCIAL HISTORY:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children: _____
Occupation: _____ Place of Employment: _____

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
Hobbies and Activities: _____

TOBACCO/ALCOHOL/SUPPLEMENTS:
Do you use Tobacco? ☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco ☐ Other: _____
How many? _____ How often? _____ How long have you used tobacco? _____
Do you use Alcohol? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _____ How often? _____
Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _____ How often? _____
Vitamin or Diet Supplements: Type: _____ How often? _____

SUBSTANCE ABUSE HISTORY:
☐ None Other: _____

MENTAL HEALTH HISTORY:
☐ None Other: _____

COMMUNICABLE DISEASE HISTORY:
☐ None Other: _____

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS:

_____

_____

Date: _____ Signature: _____