ENTERPRISE FAMILY HEALTHCARE

MEDICAL HISTORY

Patient Information		Hospitalizations or Surgery	
Name		Date	Reason
Date	SS#		
Address			
City	State Zip		
Date of Birth	Occupation		
Home Phone	Work Phone		
Cell Phone or Pager			
Chief Complaint			
Insurance Name	Insurance #		

Drug Allergies		Medications	

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other		Cholesterol		Other	

Medical History

Abdominal pain (chronic)		Gout		Rashes/Hives		Females Please Complete			
Allergies/Hay Fever		Hair Loss		Sexual/Menstrual Dysfunction		Pregnant	Yes		No
Anemia/Bruise Easily		Headaches-Frequent		Sinus Trouble		Planning Pregnancy?			
Ankles-Swollen		Heart Murmur		Stools-Bloody or Tarry			Yes		No
Appetite-Loss of		Hemorrhoids		Stroke		Menstrual Flow :			
Arthritis/Rheumatism		Hernia		Swallowing Difficulty				Regular	
Asthma/Wheezing		High Blood Pressure		Tetanus				Irregular	
Back Pain –Recurrent		Indigestion or Heartburn		Throat-Sore-Frequent				Pain/Cramps	
Bone Fracture/Joint Injury		Infections-Frequent		Thyroid Disease				Days of Flow	
Bowel Habits-Change In		Jaundice or Hepatitis		Tremors/Hands Shaking		Length of Cycle:			
Bronchitis/Chronic Cough		Kidney Stones		Ulcers/Peptic		1st Day of Last Period:			
Cancer		Lactose Intolerance		Urethral Discharge					
Chest Pain		Leg Pain-Walking		Urination > 2x Overnight		Pain/bleeding after sex			
Convulsions/Seizures		Memory Loss		Urination Decrease Flow		Number of:			
Diabetes		Mental Illness		Urination-Painful		Pregnancies			
Diarrhea/Constipation		Moodiness-Excessive		Urination-Loss of Control		Miscarriages			
Diphtheria		Muscle Weakness		Urine—Blood In		Abortions			
Diverticulosis		Nausea/Vomiting-Persistent		Varicose Veins/Phlebitis		Live Births			
Crohn's		Nervousness		Venereal Disease		Birth Control Method:			
Colitis		Depression		Vision-Failing					
Dizziness/Fainting		Nose Bleeds		Weight Loss-Recent		B.C. Pill Name:			
Ear Infections-Frequent		Numbness/Tingling Sensations		Chicken Pox					
Eye Infections		Osteoporosis		Measles		Date of Last PAP:			
Fatigue-Chronic		Phobias		Mumps					
Foot Pain		Pneumonia		Scarlet Fever		Flushing/Menopause			
Cold Numb Feet		Prostate Disease		Tuberculosis		Date of Last Mammogram:			
Gall Bladder Trouble		Psoriasis/Eczema		Herpes	✔				
				Other:		Normal		Abnormal	

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism							High Blood Pressure						
Asthma							Kidney Disease						
Bleeding Disorder							Mental Illness						
Cancer							Migraines						
Diabetes							Osteoporosis						
Epilepsy/Convulsions							Smoker						
Glaucoma							Thyroid Disease						
Hair Loss							Other						
Heart Disease													

Habits

Alcohol type		Diet Salt Intake		Sleep Difficulty Falling Asleep		Smoke-Packs Daily	
Amount		Fat Intake		Continuity Disturbances		How Long?	
Coffee Cups Daily		Other		Early Morning Awakening		Interested in Stopping?	
Other Caffeine		Exercise Routine		Daytime Drowsiness			
				Other			

How did you hear about us? _____

Any other information?

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