

# Complete Family Practice & Sports Medicine

## Patient History Form

(Please fill out pages 1 & 2)

### Medical History

Check symptoms you currently have or have had in the past year.

#### General

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Numbness
- Sweats

#### Gastrointestinal

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

#### Eye, Ear, Nose, Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache, Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision – Flashes/Halos

#### Men Only

- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other

#### Muscle/Joint/Bone

Pain, weakness, numbness in:

- Arms  Hips
- Back  Legs
- Feet  Neck
- Hands  Shoulders

#### Women Only

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

#### Cardiovascular

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid Heart Beat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

#### Skin

- Bruise Easily
- Hives
- Itching/Rash
- Change in Moles
- Scars
- Sore That Won't Heal

#### Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

Date of Last:  
 Menstrual Period \_\_\_\_\_  
 Last Pap Smear \_\_\_\_\_  
 Last Mammogram \_\_\_\_\_  
 Are you pregnant \_\_\_\_\_  
 Number of Children \_\_\_\_\_

#### Check conditions you have or have had in the past.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> HIV Positive       |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Measles            |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Migraine Headache  |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Pacemaker          |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia          |
|  |   | <input type="checkbox"/> Polio              |
|  |   | <input type="checkbox"/> Prostate Problem   |
|  |   | <input type="checkbox"/> Rheumatic Fever    |
|  |   | <input type="checkbox"/> Scarlet Fever      |
|  |   | <input type="checkbox"/> Stroke             |
|  |   | <input type="checkbox"/> Thyroid Problems   |
|  |   | <input type="checkbox"/> Tuberculosis       |
|  |   | <input type="checkbox"/> Ulcers             |
|  |   | <input type="checkbox"/> Venereal Disease   |

Describe serious illnesses and/or operations \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

### Family History

	FATHER	Current Health Conditions or Cause of Death	MOTHER	Current Health Conditions or Cause of Death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>	
Brothers	No. Alive	Current Health Conditions	No. Deceased	Cause of Death
Sisters	No. Alive	Current Health Conditions	No. Deceased	Cause of Death
Children	No. Alive	Current Health Conditions	No. Deceased	Cause of Death

#### CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES:

- |  |                                 |  |  |   |
|--|---------------------------------|--|--|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding Tendency   | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Tuberculosis                           |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Allergy <input type="checkbox"/> Other |

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(Please fill out pages 1 & 2)

**Medications**

List of Current Medications (Include Over The Counter and Vitamins or Supplements)\_\_\_\_\_

**Medication Allergies and Food Allergies:**

Pharmacy Name and Address\_\_\_\_\_

Pharmacy Phone Number\_\_\_\_\_

**Health Habits**

**Health habits** - Check which substances you use and describe how much you use.

- Caffeine\_\_\_\_\_
- Drugs\_\_\_\_\_
- Tobacco\_\_\_\_\_
- Other\_\_\_\_\_

**Occupational** – Check if your work exposes you to the following:

- Stress\_\_\_\_\_
- Heavy Lifting\_\_\_\_\_
- Hazardous Substance\_\_\_\_\_
- Other\_\_\_\_\_

Your Occupation:\_\_\_\_\_

Number of Tattoos\_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_

**Signatures**

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Obinna U. Chukwuocha or any staff of Complete Family Practice & Sports Medicine responsible for any errors or omissions that I may have made during the completion of this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date