Salmon Bay Family Medicine
Initial History

Name _____ Today's Date _____
Address: _____ Phone: work ( ) _____
_____ zip code _____ home( ) _____

Present Occupation _____ Age _____
Marital Status: (circle one) Single Married Partnered Divorced Widowed

Please list all concerns or questions you have about your health today _____
_____
_____

PAST MEDICAL HISTORY: List significant past operations, hospitalizations, illnesses or injuries

Year	Problem, operation or injury	Hospitalizations and or Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: Are you allergic to any medications? YES NO
If yes, list medication(s) and reaction _____
_____

List current medications (including nonprescription drugs)

Name of Medication	Dose	How many times per day	Reason for taking
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

BODY SYSTEMS REVIEW

How would you describe your health? GOOD/ FAIR / POOR

	(Circle one)
Do you tire easily to the point that limits your activity?	Yes NO
Have you lost 10 pounds or more recently without trying	Yes NO
Have you noticed any major changes in your skin or any abnormal hair loss?	Yes NO
Do you have any problems with your eyes and ears (other than glasses)?	Yes NO
Do you wheeze or develop trouble breathing with activity?	Yes NO
Is there a change in your voice or any hoarseness?	Yes NO

PLEASE TURN OVER

Do you get chest pain or tightness with activity, stress, with cold temps or at night?	Yes	NO
Do you have a history of any heart problems?	Yes	NO
Do you have frequent cough that is chronic (>6 mo.)?	Yes	NO
Are your feet or ankles often swollen?	Yes	NO
Do you have problems with swallowing, stomach or abdominal pain?	Yes	NO
Do you have heartburn or ulcers?	Yes	NO
Have you noticed any recent change in your bowel movements?	Yes	NO
Do you have any sexual problems you wish to discuss?	Yes	NO
Do you have difficulty with frequent urination, especially at night?	Yes	NO
Do you have problems holding and/or passing urine?	Yes	NO
If a woman, do you do breast self exams?	Yes	NO
If a man, do you do testicular self exams?	Yes	NO
Do you have a problem with severe headaches?	Yes	NO
Do you have any breast lumps or discharge?	Yes	NO
Do you have a problem with excessive bleeding or bruising?	Yes	NO
Do you have leg cramps with or without activity?	Yes	NO
Do you have any reason to be concerned about HIV exposure?	Yes	NO
Is there any violence in your household?	Yes	NO
Do you have any other symptoms you want to discuss?	Yes	NO

Please List_____

_____

IMMUNIZATIONS

	When		When
Last Tetanus booster (dT)	_____	Hepatitis A vaccine	_____
MMR vaccine (measles)	_____	Hepatitis B vaccine	_____
Influenza vaccine (Flu shot)	_____	Pneumococcal vaccine (Pneumovax)	_____

FAMILY HEALTH

Is your mother living? Y / N Age now or at her death?_____

Is your father living? Y / N Age now or at his death?_____

How many Brothers _____ and or Sisters_____ do you have?

Illnesses in:

Mother_____ Father_____

Brother or Sisiters_____

Circle if any family member has had any of these, and whom?:

Tuberculosis_____ Diabetes_____ Heart Attack_____

Breast Cancer_____ Stroke(brain attack)_____ High Blood Pressure_____