DeSantis Family Practice, PLLC

PREVIOUS MEDICAL HISTORY

Patient Name: ______________________________ Patient Date of Birth: ______________

Please circle YES for each condition that applies/has applied to you:

Yes	Allergies	Yes	Heart Murmur
Yes	Anemia	Yes	Heavy snoring/Sleep apnea
Yes	Anxiety	Yes	Hepatitis
Yes	Arthritis	Yes	High Blood Pressure
Yes	Asthma	Yes	High Cholesterol
Yes	Blood Clots	Yes	HIV/AIDS
Yes	Cancer-if Yes, please state type	Yes	Irritable Bowel Syndrome
	___________________________	Yes	Kidney Disease
Yes	Cataracts	Yes	Liver Disease
Yes	COPD	Yes	Meningitis
Yes	Crohn's Disease	Yes	Nerve/Muscle Disease
Yes	Depression	Yes	Osteoporosis
Yes	Diabetes	Yes	Prostate Disease
Yes	Emphysema	Yes	Seizures
Yes	Gallbladder Disease	Yes	Sickle Cell Anemia
Yes	GERD (Heartburn)	Yes	Stomach Ulcers
Yes	Glaucoma	Yes	Stroke
Yes	Headaches/Migraines	Yes	Substance Abuse
Yes	Heart Attack	Yes	Thyroid Disease
Yes	Heart Disease	Yes	Tuberculosis
Yes	Heart Failure		

FEMALES ONLY	
Age of last period	_______
# of pregnancies	_______
Age at Menopause	_______
# of children	_______
History of Abnormal Pap	
Yes	No

Please mark the box for each surgery that applies to you and year performed

		Year			Year
☐	Appendix Removal	_________	☐	Hysterectomy	_________
☐	Back/Spine Surgery	_________		☐ Total	_________
☐	Brain Surgery	_________		☐ Partial	_________
☐	Breast Surgery	_________	☐	Joint Replacement	_________
☐	Cardiac Bypass Surgery	_________		☐ Hip	_________
☐	Cardiac Stent Placement	_________		☐ Knee	_________
☐	Carpal Tunnel	_________	☐	Liver Biopsy	_________
☐	Cataract Extraction	_________	☐	Pacemaker	_________
☐	Colon Surgery	_________	☐	Prostate Surgery	_________
☐	Cosmetic Surgery	_________	☐	Small Intestine Surgery	_________
☐	Ear Surgery-Ear Tubes	_________	☐	Thyroidectomy	_________
☐	Eye Surgery/LASIK	_________	☐	Tonsillectomy/Adenoidectomy	_________
☐	Fracture Surgery	_________	☐	Valve Replacement	_________
☐	Gall Bladder Surgery	_________	☐	Vascular Surgery	_________
☐	Gastric Bypass Surgery	_________	☐	Vasectomy	_________
☐	Hernia Repair	_________			_________

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FAMILY HISTORY

Please check the appropriate boxes to indicate your family history below:

CONDITION	Mother	Father	Sister	Brother	Mom's Father	Mom's Mother	Dad's Father	Dad's Mother
Alcohol Abuse								
Allergies								
Alzheimer's Disease								
Aneurysm								
Arthritis								
Asthma								
Breast Cancer								
Colon Cancer								
COPD								
Depression								
Diabetes								
Drug Abuse								
Early Death								
Eczema								
Eye Problems								
Gastric Cancer								
Glaucoma								
Headaches/Migraines								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Learning Disabilities								
Mental Illness								
Miscarriages								
Obesity								
Osteoporosis								
Other Cancers								
Peripheral Vascular Disease								
Prostate Cancer								
Seizures								
Stroke								
Thyroid Disease								

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SOCIAL HISTORY

Yes No **Alcohol Use** **Indicate how many drinks per week:**

____________ Cans of beer
____________ Shots of Liquor
____________ Drinks containing 0.5 oz of alcohol
____________ Glasses of wine

Yes No **Sexually Active**

Yes No **Drug Use** **Type/Frequency** _________________________________

____________ Quit Date
____________ Years used

Yes No **Tobacco Use** ____________ Pack(s) per day

____________ Quit Date
____________ Years as a smoker

Yes No **Tobacco, Smokeless** **Type/Frequency** _________________________________

____________ Quit Date
____________ Years as a smoker

Yes No **Caffeine Intake** **Type/Frequency** _________________________________

Please list all medications you currently take, Prescription and Non-Prescription and dosage

Medication Name	Mg	Dosing/Frequency

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****Please indicate your preferred Pharmacy and include location:

____

Medication Allergies (check all that apply and their reaction)

Medication Allergies	Reaction	Medication Allergies	Reaction
☐ **No Drug Allergies**	**N/A**		
☐ Aspirin		☐ Oxycodone	
☐ Bactrim		☐ Penicillin	
☐ Cephalosporins		☐ Lisinopril	
☐ Coumadin (Warfarin)		☐ Sulfa	
☐ Epinephrine		☐ Gelatin	
☐ Erythromycin		☐ Latex	
☐ Ibuprofen (Advil)		☐ Tylenol	
☐ Eggs		☐ Doxycycline	
☐ Iodine		☐ Xylocaine (Lidocaine)	
☐ Heparin		☐	
☐ Keflex (Cephalexin)		☐	

Health Maintenance (List approximate year if you had the following procedures performed

Procedure	Year
Cardiac Stress Test	__________
Colonoscopy	__________
Dexa Scan (bone scan)	__________
EKG	__________
Mammogram	__________
Pap Screen	__________
Pneumonia Vaccine	__________
Flu Vaccine	__________
Shingles Vaccine	__________
Tetanus Shot	__________
	__________

Patient Signature: ____

Today's Date: ___________________________________