**First Choice Family Practice**

*Health History Form*

Name: DOB:

Medication allergies:

Medication list: *please bring an updated list from the pharmacy, or bring pills in the original bottles*

**Family History**

|  |  |
| --- | --- |
| Father |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sibling (1) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sibling (2) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sibling (3) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sibling (4) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child (1) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child (2) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child (3) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child (4) |  Alcohol and/or drug abuse  Allergies  Asthma  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression  Diabetes  Heart disease  High blood pressure  High cholesterol  Mental illness  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Continued on next page*

**Social History**

* What type of diet do you follow?  Regular  Gluten free  Low carb  Vegan  Vegetarian
* What is your exercise level?  None  Occasional  Moderate  Heavy
* What is your marital status?  Single  Married  Divorced  Widowed  Domestic partner
* What is your smoking status?  Never  Former  Current every day (packs per day: \_\_\_\_\_\_\_\_\_\_\_)
* What is your level of alcohol consumption?  None  Occasional  Moderate  Heavy
* What is your level of caffeine consumption?  None  Occasional  Moderate  Heavy
* Do you use any illicit or recreational drugs?  Yes  No
* Do you use sunscreen routinely?  Yes  No
* Do you have an advanced directive (living will, durable power of attorney)?  Yes  No

**Surgical History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure** | **Date** | **Procedure** | **Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |