

Family & Immunization History (FIH)

Patient Name: _____

Scan Password: _____

1. Please select all diseases that have been previously identified in your immediate family. Indicate whether this disease occurred on your mother's (maternal) side or your father's (paternal) side.

If you are unsure about any disease listed below, or if a disease is missing from the list, please discuss this with your physician.

"M" indicates Maternal (Mother's) side, "F" indicates Paternal (Father's) side

M	F	Disease	M	F	Disease
		No inheritable medical problems			Hearing loss
		Unknown / No information available			Heart disease
		Alcoholism			Heartburn / gastroesophageal reflux disease
		Allergies			High cholesterol / hypercholesterolemia
		Alzheimer's disease			High blood pressure / hypertension
		Arthritis (osteoarthritis)			Hyperthyroid / over-active thyroid
		Asthma			Hypothyroid / under-active thyroid
		Bleeding disorders			Iron deficiency / anemia
		Breast cancer			Lupus
		Cancer (other than breast, prostate, skin)			Mental illness (other than depression)
		Cardiovascular disease (heart attack)			Osteoporosis (brittle bones)
		Crohn's disease			Prostate cancer
		Degenerative joint disease (gout)			Rheumatoid arthritis
		Depression			Seizures
		Diabetes			Skin cancer
		Eczema (chronic dry, itchy skin)			Ulcerative colitis (chronic diarrhea)

2. Please select from the list below any immunization that you have received:

All my childhood immunizations are up to date	Inactivated Polio Vaccine (IPV)
Diphtheria, Tetanus (DT)	Measles, Mumps, Rubella (MMR)
Diphtheria, Tetanus and acellular Pertussis (DTaP)	Oral Polio Vaccine (OPV)
Haemophilus influenzae type b (Hib)	Pneumococcal Conjugate Vaccine (PCV)
Hepatitis A vaccine	Tetanus and Diphtheria toxoids (Td) booster
Hepatitis B vaccine (Hep B)	Varicella Vaccine (Var)

Past Medical History (PMH)

Patient Name: _____

Scan Password: _____

1. Have you been previously diagnosed with any of the following diseases?

I don't have medical problems	Degenerative joint disease / gout	Hyperthyroid / high thyroid
I don't know my medical history	Depression	Hypothyroid /low thyroid
Alcoholism	Diabetes	Iron deficiency / anemia
Allergies	Eczema (chronic dry, itch skin)	Liver disease / cirrhosis
Alzheimer's disease	Emphysema	Lower back pain /sciatica
Anesthesia reaction	Fibromyalgia	Lupus
Arthritis / osteoarthritis	Glaucoma	Menopause
Asthma	Hay fever	Mental illness
Bleeding disorders / hemophilia	Headaches	Migraines
Breast cancer	Hearing loss	Osteoporosis / brittle bones
Cancer other than breast, prostate or skin	Heart disease	Parkinson's disease
Cardiovascular disease/heart attack	Heartburn / gastroesophageal reflux	Prostate cancer
Carpal tunnel syndrome	Hemorrhoids	Rheumatoid arthritis
Cerebrovascular disease / stroke	Hepatitis infection	Seizures / epilepsy
Constipation	Hernia	Skin cancer
Chronic upset stomach / gastritis	Herpes zoster / shingles, chickenpox	Tabacco abuse
Chronic diarrhea / ulcerative colitis	High cholesterol / high lipid levels	Tuberculosis
Crohn's disease	High blood pressure / hypertension	Ulcers

2. Have you had any of the following surgeries?

Abdominal surgery / bowel resection, hernia repair	Hip surgery / full hip replacement
Appendix removal / appendectomy	Knee surgery / arthroscopy, full knee replacement
Back surgery	Nasal or sinus surgery / rhinoplasty
Breast surgery / mastectomy, augmentation, lumpectomy	Shoulder surgery
Ear surgery / ear tubes	Throat surgery / tracheotomy
Eye surgery / cataract removal, cornea! transplant	Tonsils and/or adenoids removed
Foot or ankle surgery / bunion removal, tendon repair	TURP or prostate surgery
Gallbladder removal	Urinary tract surgery
Hand or wrist surgery / carpal tunnel repair	Uterine surgery /hysterectomy
Heart surgery / angioplasty, heart bypass	

Social History (SH)

Patient Name: _____

Scan Password: _____

1. What is your marital status?

- Single
- Married
- Divorced
- Separated
- Widowed
- Remarried

4. How many children live in the household?

5. How many adults live in the household?

- | | |
|----|----|
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |
| 10 | 10 |

2. What are your living arrangements?

- House
- Shared House
- Apartment / Condo
- Town home
- Trailer
- Care Facility
- Homeless
- Other

6. What is the highest level of education you've reached?

- Grade School
- Some High School
- High School Graduate
- Some College
- College Graduate
- Post-Graduate

3. How many children do you have?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- None (go to # 5)

7. Employment:

- Currently employed
- Currently unemployed
- Retired
- Student

8. Additional Comments:

I have a full time caregiver

Social History (SH)

Today's Date:_____

Patient Name:_____

9. Please tell us about any prior or current smoking habits:

I have never smoked tobacco (go to #12)

I currently smoke tobacco

I quit this year

I quit less than 3 years ago

I quit less than 5 years ago

I quit less than 10 years ago

I quit over 10 years ago

I smoked in the past only

10. How many years have you used tobacco?

- | | |
|----|----|
| 1 | 20 |
| 2 | 25 |
| 3 | 30 |
| 5 | 35 |
| 8 | 40 |
| 10 | 45 |
| 15 | |

11. If you smoke presently, how many cigarettes per day do you smoke?

- | | |
|---|--------------------|
| 1 | 10 (half a pack) |
| 2 | 20 (one pack) |
| 3 | 30 (pack & a half) |
| 4 | 40 (two packs) |
| 5 | |

Patient Name: _____ MRN# _____

PATIENT MEDICATION LIST

MEDICATION NAME	DOSAGE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the pharmacies that you use most often.

Name of pharmacy

Pharmacy address or street name

_____	_____
_____	_____
_____	_____