**GAINESVILLE FAMILY PRACTICE**

**PERSONAL HEALTH HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PLEASE CHECK EITHER*: ❒ Y or ❒ N *(please explain any yes answers)*

**PAST HISTORY**

Childhood (infancy through teens) Adult (age 20 to present)

Serious Illness? ❒ Y ❒ N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Serious Illness? ❒ Y ❒ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery? ❒ Y ❒ N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery? ❒ Y ❒ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations? ❒ Y ❒ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospitalizations? ❒ Y ❒ N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies? ❒ Y ❒ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies? ❒ Y ❒ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** *(Parents, Siblings, Grandparents, Aunts, Uncles)*

Heart Disease? ❒ Y ❒ N Diabetes? ❒ Y ❒ N Cancer? ❒ Y ❒ N

High Blood Pressure? ❒ Y ❒ N Stroke? ❒ Y ❒ N Depression? ❒ Y ❒ N

**SYSTEM REVIEW**

***Respiratory Tract***

Chronic cough? ❒ Y ❒ N Cough Blood? ❒ Y ❒ N Easily short of breath? ❒ Y ❒ N

Sinus trouble? ❒ Y ❒ N Allergy Shots? ❒ Y ❒ N Chest Pain? ❒ Y ❒ N

***Heart and Blood Vessels***

Chest pain? ❒ Y ❒ N Prior Heart Attack? ❒ Y ❒ N Leg pain with walking? ❒ Y ❒ N

Palpitations? ❒ Y ❒ N Fluid in feet? ❒ Y ❒ N

***Gastrointestinal Tract***

Heartburn? ❒ Y ❒ N Ulcers? ❒ Y ❒ N Hiatal Hernia? ❒ Y ❒ N

Chronic nausea? ❒ Y ❒ N Cramping? ❒ Y ❒ N Poor Appetite? ❒ Y ❒ N

Chronic diarrhea? ❒ Y ❒ N Blood in stools? ❒ Y ❒ N Pain in abdomen? ❒ Y ❒ N

Change in stools? ❒ Y ❒ N

***Skins and Nails***

Chronic rash? ❒ Y ❒ N New moles? ❒ Y ❒ N Frequent sun exposure? ❒ Y ❒ N

***Neurologic System***

Frequent headaches? ❒ Y ❒ N Migraines? ❒ Y ❒ N Numbness? ❒ Y ❒ N

Fainting spells? ❒ Y ❒ N Double vision? ❒ Y ❒ N Seizures in past? ❒ Y ❒ N

***Skeletal System***

Joint pains? ❒ Y ❒ N Broken bones? ❒ Y ❒ N Sprained joints? ❒ Y ❒ N

Back pain? ❒ Y ❒ N Arthritis? ❒ Y ❒ N

***Questions for MEN***

Painful urination? ❒ Y ❒ N Difficult urination? ❒ Y ❒ N Blood in urine? ❒ Y ❒ N

Discharge from penis? ❒ Y ❒ N Nighttime urination? ❒ Y ❒ N (if yes, how many times per night?) ­­\_\_\_\_\_\_\_\_\_

Sexual difficulty? ❒ Y ❒ N

**PLEASE TURN PAGE AND COMPLETE BACK SIDE**

***Questions for WOMEN***

Painful urination? ❒ Y ❒ N Difficult urination? ❒ Y ❒ N Painful menses? ❒ Y ❒ N

Irregular menses? ❒ Y ❒ N Birth Control Pills? ❒ Y ❒ N Number of Pregnancies? ­­­\_\_\_\_\_\_\_\_\_\_\_

Number of children? ­­\_\_\_\_\_\_\_\_\_ Vaginal Discharge? ❒ Y ❒ N Date of last PAP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of onset of menses? \_\_\_\_\_\_ Age at onset of Menopause? \_\_\_\_\_\_\_ Hot flashes? ❒ Y ❒ N

Sexual difficulties? ❒ Y ❒ N Uterus removed? ❒ Y ❒ N Uterus removed? ❒ Y ❒ N

***General Questions***

Weight loss? ❒ Y ❒ N Weight gain? ❒ Y ❒ N No interest in eating? ❒ Y ❒ N

Difficulty sleeping? ❒ Y ❒ N Always tired? ❒ Y ❒ N Always feel cold? ❒ Y ❒ N

What was your highest weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATIONAL HISTORY**

Current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous occupations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any job-related injury? ❒ Y ❒ N Any chemical or fumes exposure? ❒ Y ❒ N

Any job disability? ❒ Y ❒ N

**SOCIAL HISTORY**

***Habits***

Smoker? ❒ Y ❒ N How much? ­­­­\_\_\_\_\_\_\_\_\_\_\_ When started? \_\_\_\_\_\_\_\_\_\_\_ When stopped? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ❒ Y ❒ N *If yes, (Please circle):* Beer Wine Liquor Cordials

Please circle the level of alcohol consumption: None Occasional Weekends Daily Heavy

Have you used illegal drugs? ❒ Y ❒ N

Have you had a sexually transmitted disease? ❒ Y ❒ N

Do you think you may have any activity that puts you at risk of HIV/AIDS? ❒ Y ❒ N

IS THERE ANY ADDITIONAL HEALTH HISTORY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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