

61 Norfolk Family Medicine, P.C.
DATABASE TOOL
Medical and Personal History

Patient Name: _____ Date: _____

DOB: _____ Sex: M / F Race: _____

For what reason are you here today? _____

Please check conditions which you have had?

GENERAL

- Serious Infections (e.g. pneumonia) _____
- Diabetes Mellitus
- Rheumatic Fever
- HIV Infection
- Cancer (where?) _____

HEENT

- Glaucoma
- Allergies "hay fever"
- Frequent Ear Infections
- Frequent Sinus Infections

LYMPHATIC / HEMATOLOGIC

- Thyroid Goiter
- Over Active Thyroid
- Under Active Thyroid
- Transfusions
- Anemia

- Kidney Stones
- Kidney Failure
- Prostate Disease
- Endometriosis
- Sex Transmitted Infection

CVS

- High Blood Pressure
- Congestive Heart Failure
- Heart Murmur
- Heart Valve Disease
- Angina
- Heart Attack
- High Cholesterol
- Abnormal Heart Rhythm
- Blood Clots in Veins
- Blocked Arteries in Neck
- Blocked Arteries in Legs

RESPIRATORY

- Asthma
- Emphysema
- Blood Clots in Lungs
- Sleep Apnea

GI / GU

- Stomach Ulcers
- Ulcerative Colitis
- Crohns Disease
- Bleeding from Intestines
- Diverticulitis
- Colon Polyps
- Irritable Bowel Disease
- Hepatitis
- Cirrhosis of the Liver
- Liver Failure
- Pancreatitis
- Gallstones

SKIN / BREAST

- Acne
- Eczema
- Psoriasis
- Fibrocystic Breast Disease

MUSCULOSKELETAL / EXTREMITIES

- Osteoporosis
- Rheumatoid Arthritis
- Degenerative Joint Disease
- Fibromyalgia
- Neck Pain (herniated disc)
- Back Pain (herniated disc)

NEUROLOGIC / PSYCHIATRIC

- Chronic Vertigo (Meniere's)
- Peripheral Nerve Disease
- Migraine Headaches
- Stroke
- Multiple Sclerosis
- Depression
- Anxiety

Doctor's Notes: _____

Please indicate any surgeries you have had and the year you had them.

- | | | | |
|-----------------------------|----------------------------|----------------------|---------------------|
| Year | Year | Year | Year |
| ___ Angioplasty | ___ Trauma Related Surgery | ___ Stomach Surgery | ___ Tubal Ligation |
| ___ Carotid Artery Surgery | ___ Back or Neck Surgery | ___ Inguinal Hernia | ___ C-Section |
| ___ Other Vascular Surgery | ___ Hip Surgery | ___ Colonoscopy | ___ Hysterectomy |
| ___ Coronary Bypass Surgery | ___ Knee Surgery | ___ Gallbladder | ___ Ovary Removed |
| ___ Chest / Lung Surgery | ___ Carpal Tunnel Surgery | ___ Appendectomy | ___ Breast Surgery |
| ___ Tonsillectomy | ___ Sinus Surgery | ___ Prostate Surgery | ___ Thyroid Surgery |
| ___ Neurosurgery | ___ Ear Surgery | ___ Bladder Surgery | ___ other _____ |

Doctor's Notes: _____

Please indicate when you last had any of the following preventative tests or services.

- | | | | |
|-----------------------|-----------------------|--------------------------------|--------------------------------|
| Year | Year | Year | Year |
| ___ Cardiac Angiogram | ___ Flu Vaccine | ___ Prostate Cancer Blood Test | ___ Mammogram / Breast Exam |
| ___ Stress Test | ___ Pneumonia Vaccine | ___ Rectal Exam | ___ Pap Smear |
| ___ Echocardiogram | ___ Tetanus Vaccine | ___ Colon Cancer Stool Test | ___ Date of Last Physical Exam |
| ___ Chest X-ray | ___ Hepatitis Vaccine | ___ Flexible Sigmoidoscopy | ___ other _____ |
| ___ EKG | ___ Bone Density Test | ___ Barium Enema | |

Doctor's Notes: _____

Please list any allergies or intolerance to drugs or other substances. _____

Please list the medications currently taken, their dosages, and how many times per day you take them.

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Notes: _____

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbo	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___days / wk	herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past / active cigarette / cigar / pipe snuff / dip / chewing Start _____ Stop _____ packs per day _____	never / past / active liquor / wine / beer ___drinks per day / week / month AA / Alcohol Rehab	never / past / active cocaine / marijuana heroin / amphetamine barbiturate / LSD / PCP IV Drug Abuse / Drug Rehab	never / past / active coffee / tea / soda ___cans / cups per day

Doctor's Notes: _____

