Capital Family Physicians, P.A.

Patient History

Patient's Name ______________________________ **Account No.** ____________________

1. Are you allergic to any medications? ________ Which ones and what reaction occurs? ____________________

____

2. Do you use tobacco products? ________ What kind? ______________ How many? ____________
   If you smoked in the past, when did you quit? ____________________

3. Do you drink alcoholic beverages? ________ Which ones? ______________________________
   How often do you drink them? ____________________

4. Date of last: Chest X-Ray ____________ TB Skin Test ____________ Result ____________
   EKG ____________ Tetanus Shot ____________
   Eye Exam ____________
   Women Only: Last Menstrual Period ______________ Pap Smear ______________
   Mammogram ______________

5. Past Medical Hospitalizations / Surgery:

   Date **Reason**

____

____

____

6. Family History: Please check if a blood-related family member has had any of the following:

☐ TB	☐ Heart Disease	☐ Bleeding Tendency
☐ Rheumatic Fever	☐ High Blood Pressure	☐ Anemia
☐ Diabetes	☐ Strokes	☐ Arthritis
☐ Thyroid Diseases	☐ Lung Disease	☐ Mental Disease
☐ Cancer	☐ Kidney Disease	☐ Glaucoma

☐ Other ____

7. Other things about your health you wish the doctor to know: ______________________________

____

8. Do you have any chronic conditions? ____

Please fill in this chart	Age (if living)	Age at Death	State of Health / Details	Cause of Death
Mother				
Father				
Brother (s) How Many?				
Alive ______ Dead ______				
Sister (s) How Many?				
Alive ______ Dead ______				
Children How Many?				
Alive ______ Dead ______				