

TABLE ROCK FAMILY MEDICINE

PATIENT HISTORY

Name _____ Date _____

Please fill in the following information on your family history:

<u>Living? Relative</u>	<u>Age or Age at Death</u>	<u>Health Problems or Cause of Death</u>
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_____ Father _____

_____ Mother _____

_____ Sister _____

_____ Brother _____

_____ Grandparents _____

_____ Son _____

_____ Daughter _____

Other Family History? _____

Who do you live with? _____

Marital Status _____

Education _____

Occupation _____

Do you smoke? ___ no ___ yes How many packs a day? _____

Do you drink coffee, tea, or caffeinated beverages? ___ no ___ yes
How much a day? _____

Do you drink alcohol? ___ no ___ yes How much a day? _____

Do you use recreational drugs? ___ no ___ yes

Do you exercise? ___ no ___ yes

Are you sexually active? ___ no ___ yes

Do you eat a special diet? ___ no ___ yes What kind? _____

Do you wear your seatbelt? ___ no ___ yes

Are there firearms in your home? ___ no ___ yes

What are your hobbies? _____

Are your vaccines up to date? ___ no ___ yes ___ do not know

Do you have a living will? ___ no ___ yes

Are you an organ donor? ___ no ___ yes

Have you ever been in the hospital or had surgery? ___ no ___ yes

If yes, list below:

<u>Date</u>	<u>Reason for Hospitalization/Surgery</u>
_____	_____
_____	_____
_____	_____