

# St. Francis Family Health Care

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

## Patient Medical History

Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bladder Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Transfusions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chickenpox	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mitral Valve Prolapse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Venereal Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hives or Eczema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of last chest x-ray _____			Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type _____		
Osteo Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Thyroid Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rheumatoid Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Others _____			Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Back Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes						
Allergies/Intolerances	<input type="checkbox"/> None							

Allergies- Please list the reaction if known \_\_\_\_\_  
\_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses \_\_\_\_\_  
\_\_\_\_\_

Obstetrical History (# of deliveries, miscarriages, sterilization) \_\_\_\_\_

## Patient Social History

Marital Status:  Single  Married  Separated  Divorced  Widowed  Other  
Use of alcohol:  Never  Rarely  Moderate  Daily  
Use of tobacco:  Never  Previously, but quit: \_\_\_\_\_  Current packs/day \_\_\_\_\_  
Use of drugs:  Never  Type/frequency: \_\_\_\_\_  
Excessive exposure  
At home or work to:  Fumes  Dust  Solvents  Airborne Particles  Noise

## Family Medical History

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

Do you have problems with any of the following that might effect your care or understanding of your medical condition or treatment?

Physical	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emotional	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reading	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cognitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spiritual	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Writing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cultural	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Visual	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Speech	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Language	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Religion	_____	

## Advanced Directive

Do you have an advanced directive? \_\_\_ Yes \_\_\_ No If yes, do we have a copy of your advanced directive on file? \_\_\_ Yes \_\_\_ No  
If no, we need a copy of your advanced directive for your medical record. If you do not an advanced directive and would like more information on this subject, there is a handout available.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship, if other than the Patient \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_