NORTHEAST IOWA FAMILY PRACTICE CENTER

Family Practice Center
Patient/Family History

Patient Name: _____ Date of Birth: _____

Do you have any allergies to medications? _____

GYNECOLOGY History (if female)

Do you have any history of an abnormal pap smears? _____

OBSTETRIC History (if female)

Total number of pregnancies _____

Number of full term pregnancies _____

Number of premature pregnancies _____

Number of induced abortions _____

Number of miscarriages _____

Number of ectopic pregnancies _____

Number of multiple births (twins, etc) _____

Number of living children _____

FAMILY HISTORY

List of medical problems your parents/grandparents/siblings/children/aunts/uncles have. Please note if it is on your father or mother's side:

_____

_____

_____

SOCIAL HISTORY

Smoker or non smoker (circle one)

If a smoker, how many packs per day: _____

Do you use chewing tobacco? _____

How many years have you been a smoker? _____ What age did you begin smoking? _____

Are you exposed to passive smoke? _____

Do you live alone or with others? If with others, who? _____

Marital Status: (circle one) single/married/widowed/divorced/separated/domestic partner

Number of children: _____

Do you have an advance directive? _____

How many years of education do you have? (circle one) High school/2 year college/4 year college/post grad

Are you currently employed? Yes ____ No ____

If yes, what is your occupation? _____

SURGICAL HISTORY: List type of surgery and year if known:

_____

_____

_____

PAST MEDICAL HISTORY: (If yes, write number in NOTES below and explain)

1. Abuse/Domestic Violence	Yes/No	22. Infertility	Yes/No
2. Alcohol overuse/alcohol abuse	Yes/No	23. Kidney disease	Yes/No
3. Allergies/Hayfever	Yes/No	24. Liver disease	Yes/No
4. Anesthesia complications	Yes/No	25. Mental health	Yes/No
5. Back Pain	Yes/No	26. Neck pain	Yes/No
6. Birth defects or inherited disease	Yes/No	27. Neurologic problems	Yes/No
7. Bladder or kidney problems	Yes/No	28. Obesity	Yes/No
8. Brain injury	Yes/No	29. Osteoporosis	Yes/No
9. Breast problems	Yes/No	30. Ostomy	Yes/No
10. Cancer	Yes/No	31. Paralysis	Yes/No
11. Constipation	Yes/No	32. Respiratory disorder	Yes/No
12. Developmental or behavioral disorder	Yes/No	33. Rheumatologic disease	Yes/No
13. Diabetes	Yes/No	34. Sinus problems	Yes/No
14. Ear or hearing problems	Yes/No	35. Skin problems	Yes/No
15. GYN problems	Yes/No	36. Sleep apnea	Yes/No
16. Gastrointestinal disease	Yes/No	37. Sleep disorder	Yes/No
17. Heart disease	Yes/No	38. Stroke	Yes/No
18. Hematologic disease	Yes/No	39. Thyroid disease	Yes/No
19. Hyperlipidemia	Yes/No	40. Urinary problems	Yes/No
20. Hypertension	Yes/No	41. Vascular disease	Yes/No
21. Infections	Yes/No	42. Vision/eye disease	Yes/No

NOTES: