Totem Lake Family Medicine

Basic History Age 18 and Over

NAME_____ DOB_____/_____/_____ DATE _____/_____/_____

Please bring this form with you for your exam on:_____

Current Health Summary

Do you have any health concerns at this time?_____

_____

_____

Health Habits:

	Yes	No
Do you currently smoke cigarettes?	☐	☐
If yes, how many per week?_____		
How long have you smoked?_____		
If no, have you ever smoked?	☐	☐
Do you use smokeless tobacco?	☐	☐
Do you drink alcohol?	☐	☐
How many drinks per week?_____		
Have you ever:		
Felt the need to cut down on drinking?	☐	☐
Felt annoyed by criticism of drinking?	☐	☐
Had guilty feelings about drinking?	☐	☐
Taken a morning eye opener?	☐	☐

	Yes	No
Do you exercise regularly?	☐	☐
How often do you exercise?_____		
What type of exercise?_____		
_____		
_____		

Life Changes within the last 12 months:

A new marriage?	☐	☐
A new divorce/separation?	☐	☐
Major illness or death in your family?	☐	☐
Personal illness or injury?	☐	☐
Gain of a new family member?	☐	☐
Change in job or home?	☐	☐

Body Systems Review:

	Yes	No	Uncertain
1. How would you describe your health? ☐ Good ☐ Fair ☐ Poor			
2. Do you tire easily?	☐	☐	☐
3. Have you noticed any major changes in your skin (moles, rashes, etc)?	☐	☐	☐
4. Do you have trouble with your eyes or ears (other than a need for glasses)?	☐	☐	☐
5. Are you short of breath, hoarse, or prone to wheezing or coughing?	☐	☐	☐
6. Do you have chest pain with activity?	☐	☐	☐
7. Do you have a heart murmur?	☐	☐	☐
8. Are your feet or ankles swollen often?	☐	☐	☐
9. Do you have trouble swallowing, heartburn, stomach pain or ulcers?	☐	☐	☐
10. Have you noticed blood or any recent change in your bowel movements?	☐	☐	☐
11. Do you have any sexual problems you wish to discuss?	☐	☐	☐
12. Do you have difficulty urinating or holding your urine?	☐	☐	☐
13. Do you have a back, joint, or muscle problem that interferes with work or life?	☐	☐	☐
14. Do you often have a problem with severe headaches?	☐	☐	☐
15. Do you have trouble sleeping?	☐	☐	☐

Physician Comments:

_____

_____

_____

_____

_____

Women Only:

	Yes	No	Uncertain
1. Do you have breast lumps, lumps in your armpit, or discharge from your nipples?	☐	☐	☐
2. Is there a chance you are pregnant?	☐	☐	☐
3. Have you ever had an abnormal pap smear?	☐	☐	☐
If yes, how long ago?_____			
4. Do you do a monthly breast exam?	☐	☐	☐
5. Number of times pregnant:_____			
6. Number of living children:_____			
7. Do you have periods?	☐	☐	☐
Frequency of periods?_____			
Last menstrual period?_____			

Immunizations:

1. Have you had a tetanus booster since 2007?	☐	☐	☐
2. Have you ever had a Pneumovax shot (pneumonia shot)?	☐	☐	☐
3. Have you ever had a Zostavax shot (shingles shot)?	☐	☐	☐

Advanced Directives:

1. Do you currently have a living will?	☐	☐	☐

Family Health:

	Yes	No	
1. Is your mother living?	☐	☐	Age now or at death:_____
2. Is your father living?	☐	☐	Age now or at death:_____

Illness in Family:

Mother:_____

Father:_____

Brothers or sisters:_____

Has any family member had:	Yes	No	How are they related to you?
Tuberculosis	☐	☐	_____
Diabetes	☐	☐	_____
Heart attack	☐	☐	_____
Breast cancer	☐	☐	_____
Other cancer	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke	☐	☐	_____
Depression	☐	☐	_____
Sickle cell anemia	☐	☐	_____

Name any conditions that run in your family:

_____

_____

_____

Past Medical History:

_____

_____

_____

_____

_____

Past Surgical History:

_____

_____

_____

_____

_____

Work Information:

1. Current occupation:_____
2. Usual occupation (kind of work done during most of life even if retired):_____
3. Kind of business or industry:_____
   Employer:_____
4. Briefly describe what you do at work:_____
5. What are your hobbies or interests outside work?_____

Current Medications:

Drug or Medication	Dosage	For What Reason

Do you use any method to prevent pregnancy? Yes ☐ No ☐

If yes, which?_____

Please list any non-prescription medications you take (for example- aspirin, laxatives, Geritol, vitamins, supplements, etc.):

_____

_____

_____

_____

_____

_____

Are you allergic to any drugs or medications? Yes ☐ No ☐

If yes, name drug and describe reason:

_____

_____

_____

_____

_____

_____

_____