For Office Use Only
DATE REVIEWED_____MEDICAL PROVIDER_____

EAGLE FAMILY MEDICINE AT OAK RIDGE
HEALTH HISTORY DATA BASE

This visit is intended as a Wellness visit, to focus on Health Maintenance issues rather than medical problems. Please indicate here if there is anything else, you need this visit:
*Refills*_____*Forms*_____

Current Medical History
NAME_____AGE_____DATE OF BIRTH_____
MARITAL STATUS_____RACE_____

Are you taking any medicine at present time? YES_____ NO_____
If YES, list below. Include over the counter medicine, as well as herbs.

NAME OF MEDICATION WHEN BEGUN DOSE

Are you allergic to any medication? YES _____ NO _____
If YES, list below.

NAME OF MEDICATION TYPE OF REACTION

Circle if you are allergic to any of the following: bee stings, pollen, molds, grass, foods, do not know.

PAST MEDICAL HISTORY:
Please list any hospitalizations for any medical or surgical problems, including childbirth.
DATE NAME/ADDRESS OF HOSPITAL DR'S NAME REASON

List any serious medical or surgical problems for which you were not hospitalized.
DATE PROBLEM

PAST MEDICAL HISTORY

Have you ever had a blood transfusion? YES_____ NO_____

Have you ever had a chest x-ray? YES_____ NO_____ Where? _____

Have you had any other x-rays recently? YES_____ NO_____

When did you have your last tetanus booster? DATE: _____ NO_____

Have you ever had a pneumonia vaccine? YES_____ NO_____

Have you ever had any other immunizations recently? YES_____ NO_____

What were they? _____

When was your last dental appt? _____ Last eye exam? _____

When was your last EKG? _____ Sigmoidoscopy/Colonoscopy? _____

Women: Last Pap Smear_____ Last Mammogram _____

Men: Last Prostate Exam_____ PSA Test_____

FAMILY HISTORY

	DOB	MEDICAL PROBLEMS	If deceased AGE AT DEATH	CAUSE OF DEATH
MOTHER				
FATHER				
BROTHERS				
SISTERS				
SPOUSE				
CHILDREN				

Check any of the following medical problems that may run in your family. Indicate who, using the following codes: (M-mother, F-father, S-sister, B-brother, MGM-mother's mother, MGF-mother' father, PGM-father's mother, PGF-father's father, C-child, Pt-yourself).

Diabetes_____ High Blood Pressure_____ High Cholesterol_____
Glaucoma_____ Heart Disease_____ Stroke_____
Depression_____ Alcohol/Substance Abuse_____
Asthma_____ Allergies_____ Hay Fever_____
Arthritis_____Osteoporosis_____Alzheimers_____
Cancer_____ Thyroid_____

SOCIAL HISTORY

Do you use tobacco products? YES____ NO____ If YES, what? _____
How much_____ How many years? _____
Do you consume alcoholic beverages (wine, beer, whiskey)? YES_____ NO_____
If YES, how much? _____; how many years? _____
Do you use recreational drugs? YES_____ NO_____
Do you exercise? YES_____ NO_____
Do you own any firearms? YES_____ NO_____
Do you wear seat belts? YES_____ NO_____
Do you have smoke detectors in your home? YES_____ NO_____
Occupation: _____
Education: HS grad_____ Trade School_____ College_____
Have you ever been in the military service? YES_____ NO_____

NUTRITION

Please write down what you ate yesterday.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

OF GLASSES OF WATER____
OF GLASSES OF CAFFEINE DRINKS, i.e. coffee, tea, soda_____
DO YOU EAT AT LEAST 5 SERVINGS OF FRUIT/VEGETABLES A DAY? _____

REVIEW OF SYSTEMS

Are you currently bothered by:

Do not write here

Frequent or severe headache	YES_____ NO_____	_____
Visual problems	YES_____ NO_____	_____
Hearing problems	YES_____ NO_____	_____
Dizziness	YES_____ NO_____	_____
Nosebleeds	YES_____ NO_____	_____
Hay fever	YES_____ NO_____	_____
Mouth sores	YES_____ NO_____	_____
Bleeding gums	YES_____ NO_____	_____
Painful teeth	YES_____ NO_____	_____
Hoarseness	YES_____ NO_____	_____
Difficulty/pain swallowing	YES_____ NO_____	_____
Lumps in neck	YES_____ NO_____	_____
Sore tongue	YES_____ NO_____	_____
Chest pain or tightness	YES_____ NO_____	_____
Ankle swelling	YES_____ NO_____	_____
Shortness of breath	YES_____ NO_____	_____
Nausea and/or vomiting	YES_____ NO_____	_____
Constipation	YES_____ NO_____	_____
Diarrhea	YES_____ NO_____	_____
Abdominal pain	YES_____ NO_____	_____
Heartburn	YES_____ NO_____	_____
Blood in stools	YES_____ NO_____	_____
Pain with urination	YES_____ NO_____	_____
Frequent urination	YES_____ NO_____	_____
Joint pain/stiffness	YES_____ NO_____	_____
Leg cramps at night	YES_____ NO_____	_____
Easy bruising/bleeding	YES_____ NO_____	_____
Numbness/Tingling anywhere	YES_____ NO_____	_____
Trouble sleeping	YES_____ NO_____	_____
Change in appetite	YES_____ NO_____	_____
Cry easily	YES_____ NO_____	_____
Contemplate suicide	YES_____ NO_____	_____
Anxiety	YES_____ NO_____	_____
Breast lumps	YES_____ NO_____	_____
Skin problems	YES_____ NO_____	_____
Sexual problems	YES_____ NO_____	_____
Temperature intolerance	YES_____ NO_____	_____
Night sweats	YES_____ NO_____	_____
Has your weight varied by more than 10 lbs. for the last 6 months?	YES_____ NO_____	_____
Trouble with alcohol or drugs	YES_____ NO_____	_____

Have you <u>ever</u> had or been told you had:

Glaucoma	YES_____ NO_____	_____
Pneumonia	YES_____ NO_____	_____
Tuberculosis	YES_____ NO_____	_____
Irregular heartbeat	YES_____ NO_____	_____
Heart murmurs	YES_____ NO_____	_____
High blood pressure	YES_____ NO_____	_____
Pericarditis	YES_____ NO_____	_____
Ulcers	YES_____ NO_____	_____
Diverticulitis	YES_____ NO_____	_____
Liver disease	YES_____ NO_____	_____
Hepatitis	YES_____ NO_____	_____
Gall bladder disease	YES_____ NO_____	_____
Hiatal hernia	YES_____ NO_____	_____
Kidney or bladder stones	YES_____ NO_____	_____
Arthritis	YES_____ NO_____	_____
Gout	YES_____ NO_____	_____
Infected joints	YES_____ NO_____	_____
Blood clot in legs	YES_____ NO_____	_____
Cancer anywhere	YES_____ NO_____	_____
Anemia	YES_____ NO_____	_____
Problem with blood clotting	YES_____ NO_____	_____
Thyroid disease	YES_____ NO_____	_____
Diabetes	YES_____ NO_____	_____
Stroke	YES_____ NO_____	_____
Meningitis	YES_____ NO_____	_____
Fibromyalgia	YES_____ NO_____	_____
Interstitial cystitis	YES_____ NO_____	_____
Asthma	YES_____ NO_____	_____
Chronic fatigue syndrome	YES_____ NO_____	_____
Guille Barre	YES_____ NO_____	_____
Any sexually transmitted disease	YES_____ NO_____	_____

<u>FOR WOMEN ONLY</u>

Abnormal PAP test	YES_____ NO_____	_____
Miscarriage	YES_____ NO_____	_____
Pregnancy in tubes	YES_____ NO_____	_____
Bleeding between periods	YES_____ NO_____	_____
Pain/Bleeding after intercourse	YES_____ NO_____	_____
Pain with periods	YES_____ NO_____	_____
Do you douche	YES_____ NO_____	_____
How often are your periods?	Every _____ days	
When was your last period?	_____	

<u>FOR MEN ONLY</u>

Prostate infection	YES_____ NO_____	_____
Infection of testicles	YES_____ NO_____	_____