Family Physicians
of Jonesboro

HISTORY FORM

Name________________________________ SS#______________ Date______________
Address________________________________ Occupation______________________
Phone (Home)______________ (Work)______________ Date of Birth______________ Age__________
Chief Complaint____

DRUG ALLERGIES

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____
____

CURRENT MEDICINES

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FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ☐Yes ☐ No Planning pregnancy? ☐Yes ☐No

MEDICALHISTORY

☐ Headache______________ ☐ Lactose intolerance______________ ☐Depression______________
☐Shortness of breathe______________ ☐Gallbladder disease______________ ☐Gout______________
☐Heart palpitations______________ ☐Prostate disease______________ ☐Scarlet fever______________
☐Heart murmur______________ ☐Bowel irregularity______________ ☐Chronic rashes______________
☐Chest Pain______________ ☐Incontinence______________ ☐Rheumatic fever______________
☐Dizziness/Fainting______________ ☐Sexual/menstrual dysfunction__________ ☐Mumps______________
☐Peripheral vascular disease__________ ☐Venereal Disease______________ ☐Measles______________
☐Allergies/Hay fever______________ ☐Frequent infections______________ ☐Rubella______________
☐Asthma______________ ☐Hepatitis______________ ☐Polio______________
☐Bronchitis______________ ☐Anemia______________ ☐Diphtheria______________
☐Pneumonia______________ ☐Arthritis______________ ☐Tetanus______________
☐Ulcer______________ ☐Osteoporosis______________ ☐
☐GI disorder______________ ☐Nervousness______________ ☐

HABITS

☐Smoke: Packs daily______________
How long______________
Interested in stopping?__________
☐ Exercise routine:______________
____
☐Contact with blood/bodily fluid at work: ______

☐Coffee: Cups Daily______________
Other Caffeine______________
☐Alcohol: Type______________
Amount______________
☐ Diet: Salt intake______________
Fat intake______________

☐Sleep: Difficulty falling asleep____
Continuity disturbances___
Snoring______________
Early morning awakening__
Daytime drowsiness______
Other______________