Reese Family Practice

Social History

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Name: _____ **Birthdate**: _____ **Date**: _____
Mailing Address: _____
Phone #: _____ **Can we leave you messages at this number?** _____
Emergency Contact: _____ **Phone #:** _____
Relationship to Patient: _____ **Preferred Pharmacy**: _____
Insurance:_____**Member ID#**:_____ **Group #:**_____

SOCIAL HISTORY

Single _____ **Married** _____ **Separated** _____ **Divorced** _____ **Widowed** ____ **Domestic Partner** _____
Who lives in your household? _____
Where do you work? _____
How much do you consume per day? **Water**? _____ **Caffeine?** _____ **Alcohol?** _____
Do you smoke? Cigarettes _____ **# of Packs per day?** _____ **Other tobacco use?** _____**E-cig?** _____
Do you exercise? _____ (what/how often)? _____
Primary Language: _____ **Race/Ethnicity**: _____

FAMILY HISTORY

(PLEASE GIVE APROX. AGE WHEN PERSON HAD THE ILLNESS)

	Stroke	Heart Attack	Kidney Disorder	Diabetes	High Blood Pressure	Cancer LIST TYPE	Mental Health Disorder LIST TYPE	Bleeding Disorder?	Substance Abuse LIST TYPE
YOURSELF									
Father									
Mother									
Brother(s)									
Sister(s)									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Maternal Aunt									
Maternal Uncle									
Paternal Aunt									
Paternal Uncle									

List any other diseases in the family:

_____

YOUR MEDICAL HISTORY

What serious illnesses did you have as a child? _____
What illnesses or problems have you had as an adult? _____

Hospitalization: List every time you have been hospitalized overnight:

Date	What was wrong?	What happened?	Any ongoing problems?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
___	_____	_____	_____

Surgeries:

Date	Procedure	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (Prescribed, Over the Counter and Vitamins/Supplements)

Drug Name	Strength	How often you take it	Prescriber
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

VACCINATION HISTORY: (GIVE APPROXIMATE DATES OF IMMUNIZATIONS)

MMR: _____DT (Tetanus): _____ Pneumonia: _____ TB Skin Test: _____
Hepatitis A: _____ Hepatitis B: _____ **Flu: _____**

ALLERGIES

Drug: _____Food: _____

Any other allergies:

_____

WOMEN

Age at first period: _____ Date last menstrual began: _____ How long did it last? _____
Flow of periods are: Normal _____ Heavy _____ Light _____ Regular _____ Irregular _____
Do you have pain? _____ If yes, do you require medication? _____ If yes, what medication?
_____
Date of last Pap smear? _____ Result? _____
Present type of birth control used? _____ If oral contraception, name of pill:
_____
# of Pregnancies & year: _____ # of Abortions: _____ # of Miscarriages:
_____

PLEASE LIST ANY OTHER CONCERNS REGARDING YOUR HEALTH:

_____
_____
_____
_____

REVIEW OF SYSTEMS: (Please check any systems you've experienced in the past month)

GENERAL:		Weight loss? _____	Change in heat or
Unusual fatigue: _____	Chills or fever? _____	Weight gain? _____	Cold intolerance? _____
SKIN:			
Acne? _____	Rash or Hive? _____	Possible cancer spots? _____	Bruise easily? _____
EYES,EARS,NOSE, THROAT:	Double vision? _____	Blind spells? _____	Change in vision? _____
Eye pain? _____	Hearing loss? _____	Ringing in the ears? _____	Sinus pain/ infection? _____
Earaches? _____	Difficulty swallowing? _____	Sore throat? _____	
Nose bleeds? _____			
BREASTS:			
Lumps? _____	Breast pain? _____	Nipple discharge? _____	Nursing? _____
HEART AND LUNGS:	Irregular heart beat? _____	Shortness of breath? _____	Swollen ankles or feet? _____
Chest pain? _____	Wheezing? _____	High blood pressure? _____	Discolored hands or feet? _____
Cough? _____			
GASTROINTESTINAL:	Bloody or black stools? _____	Change in stools? _____	Constipation? _____
Heartburn? _____		Nausea/Vomiting? _____	Stomach pain / cramps? _____
Diarrhea? _____	Hemorrhoids? _____	Leaking of stool? _____	
GENITAL/URINARY:			
Blood in urine? _____	Leaking urine? _____	Painful urination? _____	Up at night to urinate? _____
Sexual concerns? _____	Sexually transmitted infections? _____	Discharge from penis or vagina? _____	Lumps or pain in testicles? _____
NEUROLOGIC:	Coordination problems? _____	Frequent headaches? _____	Memory/thinking problems? _____
Tremor? _____	Fainting spells? _____	Persistent numbness? _____	Localized weakness? _____
Dizziness? _____			
MOOD/MENTAL HEALTH:		Change in appetite? _____	Depressed or sad? _____
Fatigue? _____	Sleep problems? _____	Anxious, tense or worried? _____	Marital, family, or work problems? _____
Suicidal thoughts? _____	Concentration/ memory problems? _____		
BONES/JOINTS:			
Back strain? _____	Painful or stiff joints? _____	Redness joints? _____	Neck pain? _____

Trauma? _____			