

PAOLI FAMILY MEDICINE

PAOLI MEDICAL AND PROFESSIONAL COMMONS, 250 WEST LANCASTER AVENUE, SUITE 120, PAOLI, PA 19301 • (610) 644-8069

SPOUSE (NAME & BIRTHDATE)

CHILDREN (NAMES & BIRTHDATES)

TODAY'S DATE _____
 LAST NAME _____ FIRST NAME _____
 S.S.# _____ BIRTHDATE _____ MARITAL STATUS _____
 COMPLETE ADDRESS _____
 HOME PHONE # _____ BUSINESS PHONE # _____
 OCCUPATION _____
 EDUCATION _____ YEARS HIGH SCHOOL _____ YEARS COLLEGE/POST GRAD. _____

NAME OF INSURANCE

YOUR OWN IMPRESSION OF YOUR HEALTH:

PROBLEMS OR QUESTIONS YOU WOULD LIKE TO DISCUSS:

	AGE	IF LIVING HEALTH	IF DECEASED CAUSE	AGE AT DEATH
MOTHER				
FATHER				
SISTER OR BROTHER	1.			
	2.			
	3.			
	4.			
	5.			
HUSBAND OR WIFE				
SON OR DAUGHTER	1.			
	2.			
	3.			
	4.			
	5.			

HAS ANY BLOOD RELATIVE EVER HAD (PLEASE CIRCLE RESPONSE)

	NO	YES	WHO
Asthma			_____
Allergies			_____
Glaucoma			_____
Gout			_____
Kidney Disease			_____
Arthritis			_____
Ulcers			_____
Tuberculosis			_____
Cancer or Tumor			_____
Colitis			_____
Diabetes Mellitus			_____
Heart Trouble			_____
High Blood Pressure			_____
Stroke			_____
Epilepsy			_____
Mental Illness			_____
Thyroid Disease			_____
Any Other Familial Disease			_____
Cig/Alcohol/Drugs in Home			_____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

HAVE YOU EVER HAD: (ANSWER EVERY QUESTION BY CIRCLING RESPONSE) ? MEANS UNSURE OF RESPONSE.

Scarlet Fever	NO YES	Gallbladder Disease	NO YES	Nervous Breakdown	NO YES
Mononucleosis	NO YES	Hiatus Hernia	NO YES	Concussion Or Head Injury	NO YES
Blood Transfusions	NO YES	Gastric or Duodenal Ulcers	NO YES	Neuritis or Neuralgia	NO YES
Exposure to Industrial Toxins	NO YES	Blood in the Stool	NO YES	Cancer	NO YES
Radiation Treatments	NO YES	Colitis or Bowel Trouble	NO YES	Bone Disease	NO YES
Eye Disease	NO YES	Hemorrhoids or Rectal Itching	NO YES	Bursitis or Tendinitis	NO YES
Ear Problems	NO YES	Diabetes Mellitus	NO YES	Fracture or Dislocations	NO YES
Sinusitis	NO YES	Albumin or Blood in the Urine	NO YES	Arthritis	NO YES
Hay Fever	NO YES	Thyroid Trouble	NO YES	Gout	NO YES
Recurrent Strep Throats	NO YES	Prostate Trouble	NO YES	Varicose Veins	NO YES
Skin Disease	NO YES	Difficulty Starting Urination	NO YES	Phlebitis	NO YES
Pneumonia	NO YES	Difficulty Controlling Your Urine	NO YES	Swelling of Legs	NO YES
Pleurisy	NO YES	Kidney Stones	NO YES	Cramps in Legs with Walking	NO YES
Tuberculosis	NO YES	Urinary Tract Infections	NO YES	Gonorrhea or Syphilis	NO YES
Blood Clots in the Lung	NO YES	Bleeding Problems	NO YES	Low Back Pain	NO YES
Asthma	NO YES	Anemia	NO YES	Sciatica	NO YES
High Blood Pressure	NO YES	Jaundice	NO YES	Disc Disease	NO YES
Rheumatic Fever	NO YES	Hepatitis or Liver Disease	NO YES	Any Drug Habits	NO YES
Heart Murmur	NO YES	Epilepsy or Seizures	NO YES	Any Other Disease	NO YES
Heart Trouble	NO YES	Stroke	NO YES	Denied Insurance because of Health	NO YES
Angina	NO YES	Severe Headaches	NO YES	Denied Employment because of Health	NO YES
Chest Pain with Exertion	NO YES	Meningitis	NO YES	Refused Entry into Armed Forces because of Health	NO YES

ARE YOU ALLERGIC TO: (If Yes, list reaction)

Penicillin NO YES
 Sulfa NO YES
 Aspirin NO YES
 Any Other Drug NO YES
 Any Food NO YES
 HAVE YOU BEEN HOSPITALIZED FOR ANY ILLNESS ... NO YES
 EXPLAIN: _____

HAVE YOU HAD X-RAYS OF:

Chest NO YES When _____
 Stomach NO YES When _____
 Colon NO YES When _____
 Gall Bladder NO YES When _____
 Other NO YES When _____

HAVE YOU HAD NUCLEAR SCANS DONE NO YES
 HAVE YOU HAD AN EKG ... NO YES When _____
 HAVE YOU HAD BLOOD TEST DONE NO YES
 If So, Were There Any Abnormalities NO YES
 HAVE YOU HAD A RECENT TETANUS SHOT _____
 ARE YOU TAKING ANY MEDICATION NO YES
 GIVE DETAILS: _____

HAVE YOU HAD THE FOLLOWING OPERATIONS?

Tonsillectomy or Adenoidectomy NO YES
 Hernia Repair NO YES
 Appendectomy NO YES
 Any Other Surgery NO YES
 TYPE _____ YEAR _____
 TYPE _____ YEAR _____
 TYPE _____ YEAR _____

HAVE YOU BEEN ADVISED TO HAVE SURGERY WHICH HAS NOT BEEN DONE NO YES
 DO YOU SMOKE NO YES
 If So, How Much _____
 HOW MUCH ALCOHOL DO YOU DRINK _____
 DO YOU HAVE DIFFICULTY CONTROLLING YOUR ALCOHOL INTAKE NO YES
 HOW MUCH COFFEE OR TEA DO YOU DRINK _____
 DO YOU HAVE ANY FOOD INTOLERANCES NO YES
 ARE YOU PHYSICALLY ACTIVE NO YES
 DO YOU SLEEP WELL NO YES
 ARE YOU CONCERNED ABOUT SEXUAL PROBLEMS... NO YES
 MULTIPLE SEX PARTNERS NO YES
 UNPROTECTED SEX NO YES

HAVE YOU RECENTLY HAD:

Headaches NO YES	Ear Trouble NO YES	Abdominal Pain NO YES
Eye Problems NO YES	Allergies NO YES	Vomiting Blood NO YES
Change in Appetite NO YES	Asthma NO YES	Indigestion NO YES
Tiredness or Weakness NO YES	Persistent Cough NO YES	Change in Bowel Habits NO YES
Significant Weight Loss NO YES	Productive Cough NO YES	Change in Character of Stool NO YES
Significant Weight Gain NO YES	Spitting Up of Blood NO YES	Blood in the Stool NO YES
Night Sweats NO YES	Difficulty Swallowing NO YES	Blood in the Urine NO YES
Enlarged Glands NO YES	Hoarseness NO YES	Difficulty with Urination NO YES
New Skin Growths NO YES	Shortness of Breath at Night NO YES	Excessive Thirst NO YES
Change in a Skin Growth NO YES	Shortness of Breath with Exertion NO YES	Swelling of the Feet NO YES
Lightheadedness NO YES	Chest Pain NO YES	Pain in the Feet NO YES
Fainting Episodes NO YES	Palpitations NO YES	Problems at Work or Home NO YES

WOMEN ONLY

ARE YOU HAVING MENSTRUAL PERIODS NO YES
 If So, Are They Regular NO YES
 If Not, Have You Had Vaginal Bleeding NO YES
 DO YOU HAVE HEAVY PERIODS NO YES
 DATE OF LAST PELVIC EXAM _____
 DATE OF LAST PAP SMEAR _____
 HAVE YOU EVER HAD AN ABNORMAL PAP NO YES
 ANY DIFFICULTY WITH VAGINAL DISCHARGE NO YES
 DO YOU USE ANY FORM OF BIRTH CONTROL NO YES
 If So, What Do You Use? _____
 HAVE YOU EVER USED BIRTH CONTROL PILLS NO YES
 ARE YOU TAKING HORMONES NO YES
 HOW MANY TIMES HAVE YOU BEEN PREGNANT _____
 HOW MANY LIVE BIRTHS _____
 ANY COMPLICATIONS OF PREGNANCY NO YES
 What _____
 HAVE YOU HAD ANY LUMPS IN THE BREAST NO YES