



College Park Family Care Center P.A.

PATIENT HISTORY

Please fill in as much as you can to facilitate your examination.

Patient Name: _____
 Street Address: _____
 City, State & Zip: _____
 Phone #: _____
 Vocation/ Title: _____
 Company Name: _____
 Spouse Name: _____
 How did you hear about CPFCC? _____

Today's date: ____/____/_____
 Date of last physical examination: ____/____/_____
 Date of last tetanus shot: ____/____/_____

Age: _____ Never Married
 D.O.B.: _____ Married
 Ht.: _____ Divorced
 Wt.: _____ Separated
 _____ Widow(er)

HEALTH COMPLAINTS - Please list all symptoms:

1. _____
2. _____
3. _____
4. _____

<u>List any serious medical problem:</u>	<u>Date of Onset</u>
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES - List any operations you have had:

<u>Type</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

MOST RECENT SCREENING PROCEDURES

	<u>Date</u>	<u>Result</u>
Colonoscopy	_____	_____
Flexible Sigmoidoscopy	_____	_____
DEXA Scan	_____	_____
Treadmill	_____	_____

MEDICATIONS - List any medication you take regularly including over-the-counter and vitamins or minerals:

<u>Name</u>	<u>Dosage</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

ALLERGIES - Are you allergic to any drugs? ___Yes ___No

<u>Name</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

HABITS

Do you smoke? _____ # of pkgs/day _____
 Do you chew? _____ amount/day _____
 Do you drink alcohol? _____ # drinks per day _____
 Do you drink caffeine? _____ # drinks per day _____
 Types of caffeine: _____
 List any other recreational substances or other drugs you may use: _____

 Do you exercise? _____ Describe: _____

FAMILY HISTORY

Please list names of family members.	If Living		If Deceased	
	Age	Health	Age at death	Cause if known
Father: _____				
Mother: _____				
Brother or Sister: _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				
Spouse: _____				
Children: 1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

Has any blood relative ever had:		
	Type	Who

Tuberculosis		
Diabetes		
Heart Trouble		
High Blood Pressure		
Stroke		
Birth Defects		
Asthma		
Colon Polyps		
Colon Cancer		
Skin Cancer		
Prostate Cancer		
Lung Cancer		
Breast Cancer		
Cancer, Other		

PERSONAL HISTORY

YES

- High or low blood pressure _____
- Gout _____
- Kidney disease or stones _____
- Bladder disease _____
- Difficulty in urinating _____
- Albumin, sugar, pus, etc. in urine _____
- Abnormal thirst _____
- Swelling of hands, feet or ankles _____
- Scarlet Fever or Scarletina _____
- Pleurisy _____
- Rheumatic Fever or heart disease _____
- Arthritis or rheumatism _____
- Any bone or joint disease _____
- Neuritis or Neuralgia _____
- Bursitic, Sciatica or Lumbago _____
- Gonorrhea or Syphilis _____
- Anemia _____
- Learning disabilities _____
- Emotional problems _____
- Jaundice _____
- Epilepsy _____
- Migraine headaches, frequent headaches _____
- Cancer _____
- Food, chemical or drug poisoning _____
- Hay Fever or asthma _____
- Hives or eczema _____
- Frequent infections or boils _____
- Frequent colds or sore throats _____
- Colon polyps _____
- Any other disease? Please list: _____

INJURIES: Have you had any:

YES

- Broken or cracked bones _____
- Sprains _____
- Lacerations _____
- Dislocations _____
- Concussions or head injuries _____
- Knocked unconscious _____

WEIGHT: Now _____ One year ago _____
 Maximum _____ When _____

WOMEN ONLY

- Menstrual history:
- Age at onset: _____ Regular? No _____ Yes _____
 - Days of menstrual cycle (ex 28 days): _____
 - Usual duration of period (# days): _____
 - Average # of tampons or pads used per day: _____
 - Pain or cramps? No _____ Yes _____
 - Date of last period: _____
 - Number of pregnancies : _____
 - How many children born alive? _____
 - Currently using contraception? No _____ Yes _____
 - What type? _____
 - Any family history of breast or GYN cancer? No _____ Yes _____
 - Date of last mammogram: _____
 - Results: _____
 - Date of last pap: _____
 - Results: _____
 - Your age when your first child was delivered: _____
 - History of breast biopsy: No _____ Yes _____
 - Results: _____ #: _____

Do you now or have you had:

- ENT:** Eye disease, injury, impaired sight _____
 Ear disease, injury, impaired hearing _____
 Trouble with nose sinuses, mouth, throat _____

HEAD and NECK:

- Fainting spells _____
- Convulsions _____
- Dizziness _____
- Hallucinations _____
- Enlarged thyroid or goiter _____
- Frequent or severe headaches _____
- Loss of consciousness _____
- Paralysis _____
- Depression or anxiety _____
- Enlarged glands _____
- Skin disease _____

CHEST: Chronic or frequent cough _____

- Chest pain or angina pectoris _____
- Spitting up of blood _____
- Night sweats _____
- Shortness of breath _____
- Palpitation or fluttering heart _____
- Swelling of hands or feet _____
- Extreme tiredness or weakness _____

G.I.: Stomach trouble or ulcers _____

- Indigestion _____
- Liver or gall bladder disease _____
- Colitis or other bowel disease _____
- Hemorrhoids or rectal bleeding _____
- Constipation or diarrhea _____
- Has there been any recent changes in: _____
- Your appetite _____
- Your action or stools _____
- Bowels move regularly _____

G.U.: Blood in urine _____

- Burning _____
- Fever, chills _____
- Unable to control urine _____
- Kidney or bladder stones _____

EKG: Have you ever had an electrocardiogram? _____
 Was it abnormal? _____

MEN ONLY

- Have you had: YES
- Prostatitis _____
 - Testicular pain _____
 - Urethral discharge _____
 - Infertility _____
 - Premature ejaculation _____
 - Difficulty with erection _____
- X-rays - Have you ever had x-rays of:
- Kidneys _____
 - Chest _____
 - Stomach or colon _____
 - Extremities _____
 - Back _____
 - Please list any abnormal findings: _____
 - _____
 - _____
 - _____