Imperial Valley Family Care Medical Group

(Please Complete Both Sides)

Personal Information

Your Name:	Today's Date:
Birthdate: Birthplace:	Your Doctor:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Long Term Relationship	
Your Occupation:	For How Long?

Prior Medical History

Illness		Prior Medical History		Injuries	
Anemia	☐	Cancer	☐	Head Injury	☐
Heart Disease	☐	Peptic Ulcers	☐	Broken Bones	☐
High Blood Pressure	☐	Sexually Transmitted Disease	☐	Back Injury	☐
Diabetes	☐	Pneumonia	☐	**Surgeries**	
Tuberculosis	☐	Hepatitis	☐	Hernia	☐
Stroke	☐	Kidney Disease	☐	Gallbladder	☐
Stomach Ulcers	☐	Asthma	☐	Hysterectomy	☐
Measles	☐	Back Trouble	☐	Appendectomy	☐
Mumps	☐	Blood Transfusion	☐	Prostate	☐
Arthritis	☐			Other:	
Migraine Headaches	☐				

Medicines and Drugs

Medicines Currently Taking	Medicines and Drugs		Personal Habits		
	Allergies		Smoking	☐ Yes	☐ No
	Penicillin	☐	Alcohol	☐ Yes	☐ No
	Sulfa	☐	Other Drug Use	☐ Yes	☐ No
	Other (please list)		Use Seat Belts	☐ Yes	☐ No
Over the counter medicines:					

Family History

Father: Alive - Health:

Dead - Cause:

Mother: Alive - Health

Dead - Cause

Brothers / Sisters:

Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Bowel Cancer	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No			

JLJ: 04-94 DATA\FORMS\HLTH_HX.DOC

Patient History Questionnaire

(Please Also Complete Reverse Side)

System Review

Circle Yes or No if you have recently noticed:

General			Gastrointestinal		
Significant weight change	Yes	No	Change in appetite	Yes	No
Abnormal bruising or bleeding	Yes	No	Difficulty swallowing	Yes	No
Fevers	Yes	No	Heartburn	Yes	No
			Excess gas	Yes	No
Head and Nervous			Nausea	Yes	No
Depressed mood	Yes	No	Vomiting	Yes	No
Sleeping problems	Yes	No	Vomiting blood	Yes	No
memory difficulties	Yes	No	Diarrhea	Yes	No
headaches	Yes	No	Constipation	Yes	No
dizziness or Fainting	Yes	No	Hemorrhoids	Yes	No
Eye disease or injury	Yes	No	Bleeding or black stools	Yes	No
Trouble seeing	Yes	No			
Wear contact lenses or glasses	Yes	No	**Urinary**		
Ear or hearing problems	Yes	No	Urine frequency	Yes	No
Ringing in ears	Yes	No	Frequent night urination	Yes	No
Nose bleeds	Yes	No	Painful urination	Yes	No
Sore gums	Yes	No	Blood in urine	Yes	No
			Loss of urine control	Yes	No
Breasts			Sexually active	Yes	No
Lumps	Yes	No	Safe sex activity	Yes	No
Discharge	Yes	No			
			Skin and Joints		
Cardio-respiratory			Unusual pain in joints	Yes	No
Shortness of breath	Yes	No	Swelling or stiffness	Yes	No
Short of breath lying down	Yes	No	Pain or weakness in muscles	Yes	No
Asthma or wheezing	Yes	No	Skin sores or rash	Yes	No
Significant coughing	Yes	No	Leg pain when walking	Yes	No
Coughing or spitting up blood	Yes	No	Muscle cramps	Yes	No
Chest Pains	Yes	No			
Heart Palpitations	Yes	No	**Gynecological**		
			Age when periods started	______	
			First day of last period	______	
			Usual length of periods	______	
			Usual pain with periods	Yes	No
			Number of pregnancies	______	
			Number of miscarriages / abortions	______	
			Number of children	______	

Signature / Initials of MD

Reviewing: