Divine Savior
HEALTHCARE

P.O. Box 387
Portage, WI 53901-0387

Name:
MR#:
DOB:
Date of Service

PLACE LABEL HERE
OR COMPLETE

FAMILY PRACTICE HISTORY FORM

Identifying Information

Date this form completed ___/___/___

Print name (last, first MI) _____ (maiden) _____

Birthdate: ___/___/___ Sex ☐ M ☐ F Age: _____ Phone: Home (_____) _____ Work (_____) _____

Doctor: _____ Appointment Date: ___/___/___

Are you covered by the following: ☐ Medicare ☐ Medical Assistance ☐ Worker's Compensation ☐ Veteran's Administration

Which other doctors outside of our clinic have you seen in the past 5 years? _____

Past Medical History

If you have ever had any of the following, indicate the year of onset:

Alcohol/
chemical dependency _____
Anemia _____
Anxiety _____
Arthritis _____
Asthma _____
Bleeding tendency _____
Blood clot in leg _____
Bronchitis/emphysema _____
Cancer (type) _____

Chicken Pox _____
Cholesterol Problem _____
Depression _____
Diabetes _____
Domestic Violence _____
Gout _____
Headache _____
Heart problems _____

High blood pressure _____
Hepatitis _____
Jaundice _____
Kidney disease _____
Kidney stones _____
Mental problems _____
Osteoporosis _____
Panic attacks _____
Pneumonia _____
Polio _____
Rheumatic fever _____
Sexual abuse _____

Sexually
transmitted disease _____
Stomach ulcer _____
Stroke _____
Thyroid disease/
goiter history _____
Transfusions _____
Tuberculosis (or history of
positive skin test) _____
Urinary tract infection _____
Other _____

For Women

Last menstrual period: ___/___/___ Every _____ days, lasts _____ days ☐ Regular ☐ Irregular Age at onset _____

Birth control/sterilization/family planning (Type): _____

Do you do a breast self exam? ☐ Yes ☐ No If yes, how often: _____

Do you have questions about the exam/would like instructions in breast self exam: ☐ Yes ☐ No

Have you had mammograms in the past? ☐ Yes ☐ No If yes, when _____

Last pelvic exam: _____ Last pap smear: _____

Have any pap smears been abnormal: ☐ Yes ☐ No When _____ Type of treatment: _____

Have you had bleeding after menopause: ☐ Yes ☐ No Endometrial biopsy: ☐ Yes ☐ No

Only for children less than 18 years old

Birth History: (Vaginal or Caesarean): _____ Premature: ☐ Yes ☐ No How many weeks: _____

Problems during pregnancy/birth: _____

Problems as an infant: _____

School: _____ Grade: _____

Approximate age first walked _____ first talked _____

Does your child take Fluoride? ☐ Yes ☐ No Is your child restrained in your car (car seat, seat belt)? ☐ Yes ☐ No

Immunizations (Give dates if remembered)

Measles/Mumps/Rubella _____ Diphtheria/Tetanus/Pertussis (DPT) _____ Polio _____

German Measles/Rubella _____ Diphtheria/Tetanus (dT) _____ Influenza _____

Chicken Pox (Varicella) _____ HIB _____ Hepatitis (B) _____

Pneumonia(pneumococcal vaccine) _____ Other vaccines (e.g. Hep. A, Yellow Fever, Typhoid, etc.:) _____

Health Care Maintenance

Diet: Any current restrictions in: ☐ Calories _____ ☐ Salt _____ ☐ Cholesterol/fats _____

List any types of food emphasized in diet: _____

Is your water fluoridated: ☐ Yes ☐ No ☐ Don't know

Do you know how much calcium you should take a day? ☐ Yes ☐ No _____

Exercise: What type _____ How often _____

Do you have a smoke alarm in your home? ☐ Yes ☐ No

Do you wear seat belts regularly: ☐ Yes ☐ No

Have you had a proctoscopy/sigmoidoscopy exam in the past: ☐ Yes ☐ No If yes, when _____

If over 50, have you had: Rectal exam: ☐ Yes ☐ No Stool testing for blood: ☐ Yes ☐ No

Colonoscopy: ☐ Yes ☐ No Blood test for PSA: ☐ Yes ☐ No

Family History

Family Members	Age(s)	Living/Dead	Major Illnesses/Cause of Death
Father			
Mother			
Brothers (number)			
Sisters (number)			
Grandparents			

Have any family members had any of the following illnesses? If so indicate age and relationship:

Alcoholism _____ Cholesterol problem _____ Nervous system disease _____

Asthma _____ Depression _____ Stroke _____

Bleeding tendency _____ Diabetes _____ Thyroid problem _____

Cancer _____ Hayfever _____ Tuberculosis _____

Breast: _____ Heart attack _____ Other _____

Colon: _____ Heart surgery _____

Ovarian: _____ High blood pressure _____

Prostate: _____ Mental illness _____

Other: _____

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Do you live alone: ☐ Yes ☐ No

Do you have problems with: urine leakage/flow: ☐ Yes ☐ No hearing: ☐ Yes ☐ No falling: ☐ Yes ☐ No
constipation: ☐ Yes ☐ No vision: ☐ Yes ☐ No memory: ☐ Yes ☐ No

Do you have an advanced directive, living will, or durable power of attorney? ☐ Yes ☐ No _____

Hospitalizations/Surgeries

Year	Where Treated	Type of Illness / Operation / Radiation	Doctor

Allergy (to medication): _____ Kind of Reaction (e.g., hive, rash, breathing problem): _____

Allergic to Latex: ☐ Yes ☐ No Kind of Reaction: _____

Other Allergies: _____

Drug reaction (to what): _____ Kind of Reaction (e.g. nausea, dizziness): _____

Have you or your relatives developed a fever (hyperthermia) or other reaction during a general anesthetic: ☐ Yes ☐ No

Prescription Medication (Use separate sheet if needed)

Name	Strength	How Often / When Taken

Nonprescription medications (give names and how often you use each)

Antacids _____
Calcium supplement _____
Decongestants _____
Diet pills _____
Laxatives _____
Pain relievers _____
Skin treatment _____
Sleep aid _____
Vitamins/minerals _____
Others _____
Herbal Remedies _____
Alternative Therapies (chiropractic, massage, acupuncture, homeopathy, etc.) _____

Social History

Birthplace _____ Ancestry/national origin _____ Religion _____

FINANCIAL SITUATION: ☐ Having a tough time ☐ Getting by okay ☐ Doing Well

EDUCATION (including vocational school) _____

OCCUPATION: Present _____

Types of work in the past _____

Any history of exposure to dust, noise, chemicals, fumes, asbestos: ☐ Yes ☐ No If yes, explain: _____

_____

Any previous or present disability _____

What risks to your health do you note at work _____

Military Service: ☐ Yes ☐ No Years _____ Places _____ Disability: ☐ Yes ☐ No

RELATIONSHIP STATUS: ☐ Married/When _____ ☐ Widowed/When _____ ☐ Divorced/When _____ ☐ Significant other/when _____

Partner: Age _____ Health _____ Occupation _____ Pets: _____

Number of children: Males _____ Ages _____ Females _____ Ages _____

Current household members _____

DOMESTIC VIOLENCE: At any time has a partner ever hit you, kicked you, or otherwise physically hurt you: ☐ Yes ☐ No
At any time have you been afraid of your current partner: ☐ Yes ☐ No

ALCOHOL & Do you now, or have you ever used any form of alcohol? ☐ Yes ☐ No

OTHER DRUGS: Please estimate the amount of beers/wine/shots you use per week: _____

Do you use marijuana, cocaine, heroin, etc. _____

In the last year, have you ever drank or used drugs more than you meant to: ☐ Yes ☐ No
Have you felt you wanted or needed to cut down on your drinking or drug use in the last year: ☐ Yes ☐ No

TOBACCO: Do you now or have you ever used tobacco? ☐ Yes ☐ No

If Yes, Type: _____ Amount per day _____ How many years: _____

Do you wish help in stopping smoking: ☐ Yes ☐ No Did you use tobacco but stopped: ☐ Yes ☐ No If yes, when _____

How much of the following do you drink per day: Coffee _____ Tea _____ Soft drinks _____ ☐ Regular ☐ Diet

Weight: Maximum _____ Average _____ Present _____

Your Signature: _____ Date ___/___/___

For Office Use Only

Reviewed by _____ Date ___/___/___

Updated by _____ Date ___/___/___

Updated by _____ Date ___/___/___

Updated by _____ Date ___/___/___

Updated by _____ Date ___/___/___