2/2020

CARILION CLINIC

DETAILED PATIENT/FAMILY HISTORY -- CONFIDENTIAL

PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

Preferred Name _____ Date of Birth _____

PAST MEDICAL HISTORY (Please check all that apply.)

☐ Atrial fibrillation	☐ Asthma	☐ Breast cancer
☐ Chronic kidney disease	☐ Heart attack, bypass or stent	☐ Congestive heart failure (CHF)
☐ Colon cancer	☐ COPD/Emphysema	☐ Diabetes
☐ HIV (AIDS)	☐ High blood pressure	☐ High cholesterol
☐ Low thyroid	☐ Seizure	☐ Stroke

Other/details above: _____

PAST SURGICAL HISTORY (Please check all that apply and estimate date.)

	Date		Date	Other Surgeries	Date
☐ Appendix	____	☐ CABG (heart artery bypass)	____	_____	_____
☐ Carotid Artery Blockage	____	☐ Cataract removal	____	_____	_____
☐ Gallbladder	____	☐ Colonoscopy	____	_____	_____
☐ Heart Angioplasty/Stent	____	☐ Hysterectomy	____	_____	_____
☐ Tonsils	____	☐ Vasectomy	____	_____	_____
☐ Hernia	____	☐ Tubes tied	____	_____	_____
☐ C-Section	____	☐ Neck or Back Surgery	____	_____	_____

FAMILY HISTORY
(Please check all that apply.)

	Cancer - Others	Breast Cancer	Colon Cancer	Ovarian Cancer	Prostate Cancer	H Attk, bypass	High Cholesterol	High Blood Pres.	Heart Failure	Stroke	Asthma	Osteoarthritis	Rheum. Arthritis	Diabetes	Migraines	Seizures	Thyroid Disease
Mother																	
Father																	
Sisters																	
Brothers																	
Maternal Aunts																	
Maternal Uncles																	
Paternal Aunts																	
Paternal Uncles																	
Maternal Grandmother																	
Maternal Grandfather																	
Paternal Grandmother																	
Paternal Grandfather																	
NONE IN FAMILY																	

DETAILED PATIENT/FAMILY HISTORY -- CONFIDENTIAL

HEALTH MAINTENANCE (When was your most recent...)

Physical exam ____________________ Tetanus shot ____________________ PAP smear ____________________
Cholesterol ____________________ Flu shot ____________________ Mammogram ____________________
Colonoscopy ____________________ Pneumonia shot ____________________ Bone density ____________________

Have you ever prepared an Advanced Medical Directive (Living Will)? ☐ Yes ☐ No

CURRENT MEDICATIONS AND DOSES

Medication Name (pills)	Milligrams	Tabs per dose	# Doses per day	How often used (circle)	
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
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______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed

Medication Name (inhalers)	Milligrams	Tabs per dose	# Doses per day	How often used (circle)	
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed
______________________________	________mg	________tabs	______x per day	Daily	As needed

Other Medications ____
____
____

Medication Allergies ____
____
____

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SOCIAL HISTORY (Complete all boxes that apply to you.)

Alcohol Use ☐ Current ☐ Quit (date) _____ Number of drinks/day _____
☐ Never

Tobacco Use ☐ Current ☐ Quit (date) _____ Number of packs/day _____ Type ☐ Cigarette ☐ Pipe
☐ Never ☐ Secondhand Number of years _____ ☐ Cigar ☐ Chew
☐ eCigarette
☐ Other _____

Drug Use ☐ Current ☐ Quit (date) _____ Type _____

Sexual Activity ☐ Yes ☐ No ☐ Not currently

Partners ☐ Female ☐ Male

Birth Control ☐ Condom ☐ Pill ☐ IUD ☐ Surgical
☐ Spermicide ☐ Rhythm ☐ Injection ☐ Abstinence
☐ Other _____

OTHER HISTORY

Employer_____ Years of Education _____

Spouse Name _____ Number of Children _____

DETAILED REVIEW OF SYSTEMS (Please mark all positive responses with an "X" and leave negative responses blank.)

☐ Review of systems is complete negative - no current complaints.

General ☐ Fever and/or chills
☐ Seasonal allergies
☐ Trouble sleeping
☐ Weight gain or loss

Digestion ☐ Nausea and/or vomiting
☐ Diarrhea
☐ Heartburn
☐ Constipation

Skin ☐ Rash
☐ Changing moles/skin lesions

Urine ☐ Burning, frequency, and/or urgency
☐ Incontinence

Eyes/Ears ☐ Vision changes
☐ Hearing changes

Ortho ☐ Muscle pains
☐ Joint pains
☐ Back pains

Lungs ☐ Cough
☐ Shortness of breath

Neuro ☐ Dizziness
☐ Headaches
☐ Falling down

Heart ☐ Chest pain
☐ Palpitations (irregular heartbeat)
☐ Peripheral edema (leg swelling)

Psych ☐ Depression
☐ Anxiety