Valley Family & Procedural Medicine

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's Name_____ Date of Last Exam: _____

Have you ever been hospitalized? ☐Yes ☐ No If Yes, what for? _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Shortness of breath	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney/Bladder problems
☐High blood pressure	☐Lung problems/cough	☐Stroke	☐Liver Problems/Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches/Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Tonsillitis	☐Depression/Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear Problems	☐Psychiatric care	☐Thyroid problems

Please describe any current or past medical treatment not listed above:

_____

_____

Please list your past surgeries:

_____

_____

Allergies:

Are you allergic to penicillin or any other drugs? ☐Yes ☐ No

Please list: _____

Medications:

Please list: _____

_____

Social and Preventative History

Do you currently smoke or chew tobacco? ☐Yes ☐ No If no, have you in the past? ☐Yes ☐ No

How many packs per day? _____

Do you drink alcohol, beer or wine? ☐Yes ☐ No If no, have you in the past? ☐Yes ☐ No

How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐ No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐ No

What is your occupation? _____ What is your marriage status? _____

Do you have children? _____ How many? _____

Family History

	Living		Age (or at death)	List serious illnesses
Mother	☐Yes	☐ No	_____	_____
Father	☐Yes	☐ No	_____	_____
Sisters	☐Yes	☐ No	_____	_____
	☐Yes	☐ No	_____	_____
	☐Yes	☐ No	_____	_____
	☐Yes	☐ No	_____	_____
Brothers	☐Yes	☐ No	_____	_____
	☐Yes	☐ No	_____	_____
	☐Yes	☐ No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High Blood Pressure	_____
HIV disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ☐Yes ☐ No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? ☐Yes ☐ No Diagnosis: _____

Date of last mammogram: _____ Mammogram results: _____

Have you ever had a breast biopsy? ☐Yes ☐ No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____