This questionnaire is important to your health. We will rely on your responses when treating you. Please take the time to provide this information completely and accurately.

SOUTHERN FAMILY MEDICINE, LLC
16312 Mount Airy Road, Shrewsbury, PA 17361
Phone: (717) 227-3800 ♦ Fax: (717) 227-3802
www.SouthernFamilyMed.com

PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____

Si usted no habla inglés fluido, marque por favor esta caja: ☐ ***y termine tanto de esta forma como usted puede.***

PART 1: PATIENT INTRODUCTION

Patient Name: _____
First Middle Last Suffix (Jr, III, etc.)

Address: _____
Number and Street Apartment / Unit

_____
City State Zip

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Area Code Area Code

Gender: (check one) ☐ Male ☐ Female Date of Birth: ____ / ____ / ____ (Month / Day / Year) Grade in School: _____

Soc. Sec. No.: _____ - _____ - _____ Employer: _____

If English is **not** your primary language, what is your primary language? _____ *Leave this line blank if English **is** your primary language.*

Who accompanied the patient today? _____ Relationship to patient: _____
If no one, leave blank

How did you learn about us? (check all that apply)

☐ Received advertisement by mail ☐ Found on the Internet
☐ Saw sign in front of building ☐ Other – please describe: _____
☐ Referral

If referred, by whom? _____ Relationship to you: _____

PART 2: REASON(S) FOR VISIT

Using the space provided, briefly state the 3 main reasons for your visit.

1. _____
2. _____
3. _____

If you would like to communicate with Southern Family Medicine by e-mail, please ask to see a copy of our Patient E-Mail Guidelines.

PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.

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PART 3: PREGNANCY AND BIRTH HISTORY

Did the patient's mom receive prenatal care? ☐ Yes ☐ No

Were there any illnesses or problems during the pregnancy? ☐ Yes ☐ No

If yes, please explain:_____

The patient was delivered by: ☐ Vaginal Birth ☐ Caesarean Section

At how many weeks gestation did the delivery occur? _____

What was the patient's birth weight? _____

Were there any problems at birth or in the nursery? ☐ Yes ☐ No

If Yes, please explain:_____

PART 4: DIET AND NUTRITION

As a baby, the patient was: ☐ Breast fed ☐ Bottle fed ☐ Both If breast fed, how long? _____

If formula fed, what type? _____

What is your child's present diet? _____

Is your child on fluoride or vitamins? ☐ Yes ☐ No If yes, what brand? _____

PART 5: PAST MEDICAL HISTORY

Has your child ever been in the hospital overnight? ☐ Yes ☐ No

If yes, at what age? _____ What hospital? _____ Why was he/she hospitalized? ____

_____

Has your child ever had surgery? ☐ Yes ☐ No If yes, please explain: _____

_____

Has your child ever broken a bone? ☐ Yes ☐ No If yes, please explain: _____

_____

Please check the box next to each medical problem your child has now or has had in the past and indicate the year it started:

Medical issue:		Year:	Medical issue:		Year:	Medical Issue		Year:
Chicken Pox	☐	_____	Heart problem	☐	_____	Pneumonia	☐	_____
Asthma	☐	_____	Anemia	☐	_____	Meningitis	☐	_____
Influenza	☐	_____	Diabetes	☐	_____	Kidney problem	☐	_____
Seizures	☐	_____	Eye problem	☐	_____	Hearing problem	☐	_____
Jaundice	☐	_____	Scarlet fever	☐	_____	Frequent infections	☐	_____
Eczema	☐	_____	Hives	☐	_____	Joint problem	☐	_____
Allergies	☐	_____	Diarrhea	☐	_____	Urinary tract infections	☐	_____
Anxiety/Depression	☐	_____	Constipation	☐	_____	Other*	☐	_____

* If you checked "Other," please list the other medical conditions the patient has or had:_____

_____

PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.

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PART 6: MEDICATIONS AND IMMUNIZATIONS

Instructions: Please list all medications, vitamins or supplements the patient is taking now, including non-prescription items.

Name of medication, vitamin or supplement	Dosage / Strength	Times per day	Reason

IMMUNIZATIONS / VACCINATIONS

If the patient received this vaccination:	Check here:	Date received:	If the patient received this vaccination:	Check here:	Date received:
DTP – 1st dose	☐		IPV/OPV -1st dose	☐	
DTP – 2nd dose	☐		IPV/OPV - 2nd dose	☐	
DTP – 3rd dose	☐		IPV/OPV – 3rd dose	☐	
DTP – 4th dose	☐		IPV/OPV – 4th dose	☐	
DTP – 5th dose	☐		Hib – 1st dose	☐	
MMR – 1st dose	☐		Hib – 2nd dose	☐	
MMR – 2nd dose	☐		Hib – 3rd dose	☐	
Hepatitis B – 1st	☐		Hib – 4th dose	☐	
Hepatitis B – 2nd	☐		Varicella	☐	
Hepatitis B – 3rd	☐		Other – specify:	☐	

PART 7: FAMILY HISTORY

Instructions: Please indicate which, if any, family members have had the following health issues.

Health issue			If Yes, relationship of family member:	Health issue			If Yes, relationship of family member:
Heart attack	☐ Yes	☐ No		Cancer	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No		Genetic disorders	☐ Yes	☐ No	
Seizures/epilepsy	☐ Yes	☐ No		Kidney disease	☐ Yes	☐ No	
Allergies/Asthma	☐ Yes	☐ No		Diabetes	☐ Yes	☐ No	
Stomach problems	☐ Yes	☐ No		Mental disorder	☐ Yes	☐ No	
Stroke/blood clots	☐ Yes	☐ No		Alcoholism / addiction	☐ Yes	☐ No	
Smoking	☐ Yes	☐ No		Other: _____			

Mother's age_____ Health Issues_____
Father's age_____ Health Issues_____
Sibling's age_____ Health Issues_____
Sibling's age_____ Health Issues_____
Sibling's age_____ Health Issues_____

PART 8: EXERCISE

Does the patient exercise? ☐ Yes ☐ No If yes, how often? _____

If yes, what kind of exercise? _____

PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.

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PART 9: SCHOOL/EDUCATION

What grade is your child in? _____

Is your child having any problems with learning? ☐ Yes ☐ No

Is your child having any problems getting along with other children? ☐ Yes ☐ No

Is your child receiving special help or tutoring in school? ☐ Yes ☐ No

PART 10: ALLERGIES

Please list any medications your child is allergic to: _____

Please list any foods your child is allergic to: _____

Is your child allergic to bee stings? ☐ Yes ☐ No

Are there pets at home? ☐ Yes ☐ No If yes, what type? _____

Does anyone smoke in the home? ☐ Yes ☐ No

PART 11: SAFETY

Do you have a car seat for your infant/toddler or does your older child wear a seat belt? ☐ Yes ☐ No

When riding a bicycle does your child wear a bike helmet? ☐ Yes ☐ No

If you have an infant/toddler, is your home child-proof? ☐ Yes ☐ No ☐ N/A

Do you have important emergency phone numbers listed near your phone for immediate reference? ☐ Yes ☐ No

Do you have any guns in the house? ☐ Yes ☐ No If yes, are they locked up? ☐ Yes ☐ No

PART 12: OTHER INFORMATION / CONTINUATION OF RESPONSES

Instructions: Please use the space below to:
1. Provide any additional information that you believe may be important for us to know about the patient's health, and
2. Continue any responses from previous questions (if you require additional space).

PART 13: SIGNATURES

Please sign below. By doing so, you are certifying that the responses in this questionnaire are complete and accurate to the best of your belief.

Signature of person completing this questionnaire: _____

Print your name: _____

Relationship to patient: _____

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU.

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