

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

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## 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:  Male  Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Occupation: \_\_\_\_\_  
(check one) Month Day Year

Soc. Sec. No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:  Single  Widowed  Married  Other Spouse/Partner Name: \_\_\_\_\_  
(check one)  Divorced

Spouse/Partner Occupation: \_\_\_\_\_

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

Who accompanied you to our office? \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
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: \_\_\_\_\_

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

### PART 2: REASON(S) FOR VISIT

Using the space provided, briefly state the 3 main reasons for your visit.  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.

**PART 3: PAST MEDICAL HISTORY**

**Instructions:** Please check the box next to each medical problem you have now or have had in the past and indicate the year it started.

<i>If you have or have had this:</i>	<i>Check here:</i>	<i>What year did it start?</i>	<i>If you have or have had this:</i>	<i>Check here:</i>	<i>What year did it start?</i>	<i>If you have or have had this:</i>	<i>Check here:</i>	<i>What year did it start?</i>
Mumps	<input type="checkbox"/>	_____	Thyroid problem	<input type="checkbox"/>	_____	Scarlet fever	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	_____	Whooping cough	<input type="checkbox"/>	_____	Diphtheria	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	_____	COPD / emphysema	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	_____	Heart disease	<input type="checkbox"/>	_____	Rheumatism	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Heart failure	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____	High cholesterol	<input type="checkbox"/>	_____	Joint disease	<input type="checkbox"/>	_____
Meningitis	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	_____	Blood clots	<input type="checkbox"/>	_____
Influenza	<input type="checkbox"/>	_____	Bursitis/sciatica	<input type="checkbox"/>	_____	Bladder prob.	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	_____	Gallbladder disease	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Migraine headaches	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Bowel disease	<input type="checkbox"/>	_____	Hemorrhoids	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	_____	Chlamydia	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	_____	Neuritis/neuralgia	<input type="checkbox"/>	_____	Gonorrhea	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	_____	Frequent infections	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	_____	Rectal disease	<input type="checkbox"/>	_____	Panic attacks	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	_____	Bone disease	<input type="checkbox"/>	_____	Other *	<input type="checkbox"/>	_____

\* If you checked "Other," please list the other medical conditions you have or had:

**HOSPITALIZATIONS / SURGERIES / SEVERE INJURIES**

List all times and reasons that you have been hospitalized, operated on, or severely injured.

Date	Reason for hospital admission, type of surgery and/or nature of severe injury	Doctor who treated you

**PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.**

**PART 4: PAST & PRESENT SYMPTOMS**

**Instructions:** Please check the box next to each symptom you have now or have had in the past year and indicate the year it started.

<i>If you have or have had this:</i>	<i>Check here:</i>	<i>Year started:</i>	<i>If you have or have had this:</i>	<i>Check here:</i>	<i>Year started:</i>	<i>If you have or have had this:</i>	<i>Check here:</i>	<i>Year started:</i>
Blurred vision	<input type="checkbox"/>	_____	Joint swelling	<input type="checkbox"/>	_____	Difficulty urinating	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	_____	Fainting spells	<input type="checkbox"/>	_____	Painful urination	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	_____	Discharge from ears	<input type="checkbox"/>	_____	Urinate less than usual	<input type="checkbox"/>	_____
Earaches	<input type="checkbox"/>	_____	Ringing in ears	<input type="checkbox"/>	_____	Urinate more than usual	<input type="checkbox"/>	_____
Change in taste	<input type="checkbox"/>	_____	Decrease in hearing	<input type="checkbox"/>	_____	Blood in urine	<input type="checkbox"/>	_____
Enlarged glands	<input type="checkbox"/>	_____	Recurrent nose bleeds	<input type="checkbox"/>	_____	Lose urine w/ coughing, etc.	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	_____	Persistent hoarseness	<input type="checkbox"/>	_____	Discharge from penis	<input type="checkbox"/>	_____
Muscle spasm	<input type="checkbox"/>	_____	Difficulty swallowing	<input type="checkbox"/>	_____	Pain with bowel movement	<input type="checkbox"/>	_____
Stomach pain	<input type="checkbox"/>	_____	Chronic frequent cough	<input type="checkbox"/>	_____	Blood in bowel movement	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	_____	Leg cramps at night	<input type="checkbox"/>	_____	Change in bowel movement	<input type="checkbox"/>	_____
Dentures	<input type="checkbox"/>	_____	Nausea or vomiting	<input type="checkbox"/>	_____	Vomited / coughed up blood	<input type="checkbox"/>	_____
Pain in arm(s)	<input type="checkbox"/>	_____	Wake up short of breath	<input type="checkbox"/>	_____	Fatigue	<input type="checkbox"/>	_____
Night sweats	<input type="checkbox"/>	_____	Shortness of breath	<input type="checkbox"/>	_____	Recurrent back pain	<input type="checkbox"/>	_____
Easy bruising	<input type="checkbox"/>	_____	Change in appetite	<input type="checkbox"/>	_____	Palpitations/fluttering of heart	<input type="checkbox"/>	_____
Hot flashes	<input type="checkbox"/>	_____	Abdominal cramps	<input type="checkbox"/>	_____	Nail brittleness	<input type="checkbox"/>	_____
Skin rash	<input type="checkbox"/>	_____	Change in hair texture	<input type="checkbox"/>	_____	Weakness of hands or feet	<input type="checkbox"/>	_____
Dryness of skin	<input type="checkbox"/>	_____	Inability to tolerate heat	<input type="checkbox"/>	_____	Trembling of any extremity	<input type="checkbox"/>	_____
Excessive sweating	<input type="checkbox"/>	_____	Inability to tolerate cold	<input type="checkbox"/>	_____	Hand, feet or ankle swelling	<input type="checkbox"/>	_____
Spots before eyes	<input type="checkbox"/>	_____	Eyeglasses needed	<input type="checkbox"/>	_____	Tingling of hands or feet	<input type="checkbox"/>	_____
Pain behind eyes	<input type="checkbox"/>	_____	Recurrent sore throats	<input type="checkbox"/>	_____	Leg cramps while walking	<input type="checkbox"/>	_____
Change in vision	<input type="checkbox"/>	_____	Soreness/bleeding gums	<input type="checkbox"/>	_____	Enlarged veins in legs	<input type="checkbox"/>	_____
Sinus trouble	<input type="checkbox"/>	_____	Recurrent head colds	<input type="checkbox"/>	_____	Redness or heat in joints	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	_____	Change in smell	<input type="checkbox"/>	_____	Other *	<input type="checkbox"/>	_____

\* If you checked "Other," please list the other symptoms you have or had in the past year:

**PART 5: EXERCISE**

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_

If yes, what kind of exercise? \_\_\_\_\_

**PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.**

**PART 6: MEDICATIONS / SUPPLEMENTS / IMMUNIZATIONS**

**Instructions:** Please list all medications, vitamins or supplements you are taking now, including non-prescription items.

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

**IMMUNIZATIONS / VACCINATIONS**

If you received this vaccination:	Check here:	Year received:	Have you received a booster?	Year of last booster:	Describe adverse reactions, if any:
DPT	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diphtheria	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pertussis	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tetanus	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Measles	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mumps	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rubella	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Polio	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Flu	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pneumovax	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chickenpox	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other – specify: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you had a Tuberculin (TB) skin test?    Yes    No   Year: \_\_\_\_\_ Was it:  Positive or  Negative?  
 If positive, provide the year you were treated: \_\_\_\_\_

Have you been out of the country in the last 2 years?    Yes    No   When? \_\_\_\_\_

Where did you go? \_\_\_\_\_

**PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.**

**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 failure <input type="checkbox"/> Yes <input type="checkbox"/> No		Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No		Seizure disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No		Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No		Mental disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No		Alcoholism / addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No		Suicide <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood clots <input type="checkbox"/> Yes <input type="checkbox"/> No		Other: _____	

**Instructions:** Please provide the following information about your family members. For each family member who is alive, indicate any significant health issues he/she has now. For each family member who is deceased, any significant health issues he/she had while alive.

Family Member	Deceased?	Age, if alive:	If deceased:			Health Issues
			Age at death:	Year of death:	Cause:	
Husband / Wife	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>Siblings:</i>						
#1: <input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Yes <input type="checkbox"/> No					
#2: <input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Yes <input type="checkbox"/> No					
#3: <input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Yes <input type="checkbox"/> No					
#4: <input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>Children:</i>						
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No					

**PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.**

**PART 8: ALLERGIES, SENSITIVITIES & INTOLERANCES**

**Instructions:** Please list anything you are allergic to, such as foods, medications, dust or chemicals, and indicate how each affects you (e.g., nausea, hives, difficulty breathing, etc.)

Allergic, Sensitive or Intolerant to:	Effect:

Do you live with a pet?  Yes  No If yes, what kind? \_\_\_\_\_ How many? \_\_\_\_\_  
 Do you have any adverse reactions to your pet(s)?  Yes  No

**PART 9: VISION AND DENTAL HISTORY**

**VISION / EYESIGHT:**

Date of last eye examination: \_\_\_\_\_  
 Do you wear eyeglasses or contact lenses?  Yes  No

**DENTAL:**

Date of last dental examination: \_\_\_\_\_

**PART 10: SMOKING / ALCOHOL / DRUG HISTORY**

**PLEASE NOTE:** For us to provide you with proper medical care, it is important that you answer the following questions accurately.

**SMOKING** Do you smoke now? .....  Yes  No  
 If yes: Number of years you have smoked: \_\_\_\_\_ Number of packs you smoke per day: \_\_\_\_\_  
 If you do not smoke now, have you ever smoked? .....  Yes  No  
 If yes: Number of years you smoked: \_\_\_\_\_ Year when you quit: \_\_\_\_\_  
 Do you chew tobacco? .....  Yes  No  
 Does anyone else in your house smoke? .....  Yes  No

**ALCOHOL** How many drinks do you normally have?  
 Beer: \_\_\_\_\_ per (check one):  day  week  month  
 Wine: \_\_\_\_\_ per (check one):  day  week  month  
 Hard liquor: \_\_\_\_\_ per (check one):  day  week  month  
 Have you ever had a problem with alcohol?  Yes  No

**DRUG USE** Have you ever used illicit drugs? .....  Yes  No  
 Have you ever smoked marijuana? .....  Yes  No  
 Have you ever been treated for drug use? .....  Yes  No  
 Aside from marijuana, please list other illicit drugs you have used: \_\_\_\_\_

**PLEASE TURN THE PAGE TO CONTINUE THIS QUESTIONNAIRE.**

**PART 11: 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 your health, and
2. Continue any responses from previous questions (if you require additional space).

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**PART 12: 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.*

Patient Signature: \_\_\_\_\_

If patient is unable to sign, check here and provide reason:  Reason: \_\_\_\_\_

*If you are not the patient, but you completed this questionnaire for the patient, 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: \_\_\_\_\_  
(only if different from patient)

Print your name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU.**