DOWNTOWN FAMILY HEALTH CARE

Patient Self Assessment

Name _____ Date of Birth _____ Date _____

Why are you here today?		
Current Medications:	Supplements:	Allergies:

Personal History

Social History	Y	N		Y	N		Y	N			
Caffeine Intake			Married?			Do you follow a specific diet?					
Amount:			Divorced?								
Do You Smoke?			Have Children?			Occupation?					
Pack/Day?			# Ages:								
Did You Smoke Before?			Do You Exercise?			Stress level?					
When did You Quit:			*How often?*								
Recreational Drugs?			Do You Drink Alcohol?			Who makes up your support system?					
			drinks/week:								

Medical History	Y	N		Y	N		Y	N		
Heart Attack			Diabetes			Acid Reflux			Immunizations	
Angina			Asthma			Stomach Ulcer			*Give date*	
Other Heart Disease			Emphysema			Arthritis			Tetanus	
Stroke			Cancer			Depression			Flu	
Migraines			*type:*			Anxiety			Pneum.	
						Thyroid Disease			Shingles	

Operations: *(list and give approximate date)*

Hospitalizations: *(Other than above)list reason and app. Date*

Serious Injuries: *(Other than above)list and app. Date*

Mental Illness

Other Medical Problems:

Family History

With each family member put the approximate age the listed condition occurred. If unknown just put a Y in the box

Relation	Cancer *list type*	Diabetes	Heart Disease	High Cholesterol	High BP	Asthma	Other
Father							
Mother							
Mat Grandfather							
Pat Grandfather							
Mat Grandmother							
Pat Grandmother							
Brother							
Brother							
Sister							
Sister							
Uncle							
Aunt							

Turn Over and Complete Other Side

DOWNTOWN FAMILY HEALTH CARE

Name _____ DOB _____ Date _____

REVIEW OF PRESENT HEALTH *Place an X in the box by anything you are currently experiencing.*

Present		Present		Present	
Head and Neck, Lymphatic		**Digestive Health**		**Musculoskeletal**	
	frequent headaches		heartburn		aching in muscles/joints
	neck pain		bloated stomach		swollen joints
	neck lumps or swelling		belching		loss of muscle strength
	armpit or groin swelling		stomach pains		shoulder pain
Eyes			persistent nausea		painful feet
	wears glasses		vomited blood		loss of muscle size
	blurry vision		difficulty swallowing		handicapped
	eyesight worsening		constipation		back pain
	sees double		loose bowels	**Neurological**	
	sees halo		black stool		faintness
	eye pains/itching		pain in rectum		numbness
	watering eyes		hemorrhoids		convulsions
Ears			rectal bleeding		change in handwriting
	hearing difficulty		loss of appetite, recent		trembles
	frequent ear infections	**Urinary**		**Mood**	
	earaches		night frequency		nervous with strangers
	runny ear		day frequency		difficulty in making decisions
	buzzing in ears		incontinence wets bed or clothes		lack of concentration
	motion sickness		burning on urination		depressed
Mouth			brown,black or bloody urine		cries often
	dental problems		urgency		hopeless outlook
	swelling in gums/jaw	**Male Genital**			difficulty relaxing
	sore tongue		weak urine stream		worries a lot
	taste change		prostate trouble		frightening dreams/thoughts
Nose & Throat			burning or discharge		feeling of being alone
	congested nose		lumps on testicles		losing ability to remember
	runny nose		painful testicles		loses temper
	sneezing spells		sexual difficulties		annoyed by little things
	head colds	**Female Genital**			work or family problems
	nose bleeds		Are you pregnant?		sexual difficulties
	sore throat	Date of last menstrual period:			considered suicide
	enlarged tonsils				desired psychiatric help
	hoarse voice			**General**	
Respiratory		Date of last PAP test:			weight changes (specify)
	wheezes, gasps				
	coughing spells				tend to be hot or cold
	cough up phlegm		post menopausal/hysterectomy		loss of interest in eating
	coughed up blood		noticed vaginal bleeding		always hungry
	shortness of breath		abnormal last menstrual period		more thirsty lately
Cardiovascular			heavy bleeding with periods		armpit/groin swelling
	high blood pressure		bleeding between periods		fatigue
	racing heart		bleeding after intercourse		sleeping difficulties
	chest pains		recent vaginal itching/discharge		use of sleeping pills
	dizzy spells		lump or pain in breasts		blood transfusions
	irregular heartbeat		complications with birth control		thyroid disease
	shortness of breath at night	**Obstetric History**			other (please list)
	excessive or night sweats		number of pregnancies		
	varicose veins		number of deliveries		
	numb feet		number of pre-term babies		
Skin			number of miscarriages		
	bruises easily		number of stillbirths		
	itching or burning skin		number of abortions		
	bleeds easily				