FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

Date_____

Last name_____ First name_____ Middle initial____

Date of Birth_____ Sex_____

Allergies_____

Pharmacy Name and phone number_____

Medical History

(Check all that apply)

___Smoke or vape tobacco products
___Use Alcohol
___Illicit drug use
___Coronary Artery Disease
___High Blood Pressure
___Headaches
___Anxiety
___Radiation Treatment
___Cancer_____
___Artificial Heart Valves or Joints
___Arthritis
___Sinus Disease
___Immunosuppressive Disorder
___Unintentional Weight Loss
___Sexually Transmitted Diseases
___Chronic abdominal pain
___Crohn's Disease
___Peripheral Artery Disease

___Back problems
___Diabetes
___Asthma
___Emphysema
___Epilepsy
___Congestive Heart Failure
___Hepatitis
___Liver disease
___Psychiatric Care
___Allergies to Medications
___Rheumatic Fever
___HIV/AIDS
___Stroke
___Stomach Ulcers
___High Cholesterol
___Gallstones
___IBD/IBS

Last Name_____ First Name_____ Middle Initial_____
DOB_____

Current Medications

Medication name Dosage How often is it taken

Last name_____ First name_____ Middle initial_____
DOB_____

Surgical History

Procedure Age it occurred Indication

_____
_____
_____
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_____

Family History

(List the relative affected and the disease)

___Smoke or vape tobacco products
___Use Alcohol
___Illicit drug use
___Heart problems
___High Blood Pressure
___Headaches
___Anxiety
___Radiation Treatment
___Cancer
___Artificial Heart Valves or Joints
___Arthritis
___Sinus Disease
___Immunosuppressive Disorder

___Back problems
___Diabetes
___Asthma
___Emphysema
___Epilepsy
___Circulation Problems
___Hepatitis
___Liver disease
___Psychiatric Care
___Allergies to Medications
___Rheumatic Fever
___HIV/AIDS
___Stroke

Last name_____ First Name _____ Middle initial _____

___Stomach Ulcers
___High Cholesterol
___Gallstones
___Crohn's Disease
___IBD/IBS

Seeing a Specialist? Please list their name, number and specialty below.

_____
_____
_____
_____
_____
_____
_____

Is there any other information you would like to share with use about your medical history not covered above? If so, please explain below.

_____
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Patient Signature_____