LANIER
FAMILY PRACTICE

MEDICAL HISTORY

PLEASE leave blank any section that does not apply to you

Allergies to Medication, X-Ray Dyes, or Other Substances: ☐ Yes ☐ No

If Yes, please list name and type of reaction:

_____

CURRENT MEDICATIONS (Prescriptions, over-the-counter, vitamins, herbs, etc.):

Name	Dose	Name	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	

☐ Check here and write on back if more space is needed

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain / tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough disease
16. Tuberculosis
17. Hay fever / Allergies
18. Abdominal discomfort
19. Indigestion
20. Nausea / Vomiting
21. Constipation
22. Diarrhea
23. Blood in stool
24. Ulcers
25. Unexplained weight loss / gain
26. Gall bladder disease
27. Hepatitis / Liver disease
28. Thyroid disease
29. Headaches
30. Kidney disease / Stones
31. Difficulty urinating or incontinence
32. Arthritis
33. Low back pain
34. Skin diseases
35. Blood disorders
36. Venereal disease
37. Anxiety
38. Depression
39. Anemia
40. Alcohol abuse
41. Drug abuse
42. Gout
43. Pelvic pain
44. Vaginal discharge
45. Abnormal Pap Smear
46. Abnormal vaginal bleeding

Number Specifics: _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any other significant health issues: _____

_____

_____

WHEN WAS YOUR LAST (if applicable)?

Pap Smear: _____ Breast Exam: _____ Mammogram: _____

Cholesterol: _____ Prostate Exam: _____ Colonoscopy / Sigmoidoscopy: _____

IMMUNIZATION HISTORY:

Hepatitis B: ☐ No ☐ Yes, when: _____ Flu/Influenza: ☐ No ☐ Yes, when: _____

Pneumovax: ☐ No ☐ Yes, when: _____ Tetanus: ☐ No ☐ Yes, when: _____

Other: _____ when: _____ Other: _____ when: _____

PAST SURGICAL AND HOSPITALIZATIONS

Operations: _____

_____

Hospitalizations other than for surgery: _____

_____

_____

GYNECOLOGICAL AND OBSTETRIC HISTORY (if applicable)

Age at onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

FAMILY HISTORY

Has any member of your family (parents, grandparents, siblings, etc) ever had the following:

Illness	*Which family member & aprox. age when diagnosed*
Diabetes	
High Blood Pressure	
Heart disease	
Cancer (describe type)	
Strokes	
Mental disease (anxiety, depression)	
Glaucoma	
Drug/alcohol addiction	
Bleeding disease	
Other	

PREVENTION

Do you wear car seat belts? ☐ **Yes** ☐ **No** If no, why not:_____

Do you wear a bicycle helmet? ☐ **Yes** ☐ **No** ☐ **NA** If no, why not:_____

Do you smoke? ☐ **Yes** ☐ **No** If yes, how much: _____

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No** If yes, how much: _____

Do you use drugs?(marijuana, cocaine, etc) ☐ **Yes** ☐ **No** If yes, how much: _____

Have you ever worked with chemicals or other hazardous materials? ☐ **Yes** ☐ **No** what _____

Do you engage in any activity that puts you at risk of getting AIDS? ☐ **Yes** ☐ **No**

Are you in a relationship in which you have been physically hurt (slapped, hit, pushed) by your partner? ☐ **Yes** ☐ **No**

Are you picked-on or bullied or harassed at school or work? ☐ **Yes** ☐ **No**

Do you ever feel afraid of your partner? ☐ **Yes** ☐ **No**

Do you have a “living will”? ☐ **Yes** ☐ **No**

Do you have a organ donor card? ☐ **Yes** ☐ **No**

Do you have any concerns about sex or sexuality? ☐ **Yes** ☐ **No**

Method of birth control:_____

**If you need a Living Will or Durable Power of Attorney paperwork, we have these available in our office.

THIS INFORMATION IS FOR USE BY YOUR PHYSICIAN
AS PART OF YOUR CONFIDENTIAL MEDICAL RECORD

X _____ _____

Patient / Parent (if patient is a minor) Date