Patient Health Information

Lifetime Family Care, PLLC

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Last Name	First Name	Middle Name	Age	Social Security Number
Permanent Address	Street	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	Email	
Date of Birth *(mo/day/year)*	Gender	Ethnicity	Primary Language	
Emergency Contact		Relationship	Phone Number	

I give permission for the physician to discuss my medical information with the following person (s):		
Name	Relationship	Phone Number

Healthcare Providers : *(List the name and phone number of other current physicians you are seeing and for what reason)*

Name	Phone Number	Reason

Current and Past Medical History *(List your current medical diagnosis and Date it was initially diagnosis here)*

Medical Diagnosis	Date of diagnosis	By Whom
For Example: Diabetes Type 2	1/1/1980	Dr. Jones

Allergies *(List all your known allergies and what the reaction is)*

Name of medication (s) or allergens	Reaction

Immunization *(List approximate dates for Vaccines completed)*

Vaccine	Date of Vaccine
Pneumonia	
Tetanus	
Flu	
Hepatitis A	
Hepatitis B	
Shingles	
Others:	

Medications *(List ALL your current medications, include any herbal supplement and vitamins)*

Medication Name	Dose	How it is taken

Family History:

Family	Name Age	Living	Deceased/ Age and Reason	Medical History	Age of Onset
Father					
Mother					
Brother 1					
Brother2					
Brother3					
Sister1					
Sister2					
Sister3					
Son1					
Son2					
Son3					
Daughter1					
Daughter2					
Daughter3					

Does any blood relatives have any of the following diseases?

	Mom	Dad	Sibling (s)		Mom	Dad	Sibling (s)
Heart Disease				Rheumatoid Arthritis			
Cancer				Mental Disorder			
Hypertension				Blood Diseases			
High Cholesterol				Tuberculosis			
Epilepsy				Others:			

Social History

Marital Status *(circle one)*	Single Married *(Spouse's Name:_____)* Divorce Widowed	
Living Situation:	__Alone __Spouse __Parent __Relatives __Others:_____	
Education:	Highest Grade Completed:	
Work:	____Not working	
	Part-time/Job Title:	
	Full-time/Job Title:	
Exercise:	No Exercise Routine	
	Exercise Routine:	How many times do you exercise per week?
		What type of exercise do you do?
Drug Use	____None	Drug Name:
Alcohol Use:	____None	Use: _____Less than 2 drinks per month
		_____2 or more drinks per week
		_____2 or more drinks per day
Smoking	____None	Use: How many packs per day:
		How many years:
		Former Smoker/Quit Date:

Surgical History *(List any previous surgical procedure(s) below)*

Surgery	Date	Physician and/or hospital

Review of Systems *(Check each item that you have or have had in the past.)*

General	___Fatigue	___Weakness	___Change in sleep	___Change in weight/appetite
Skin	___Itching	___Rash	___Skin Lesions	___Easy Bruising
Nervous	___headache	___Dizziness	___double vision	___Muscle weakness
	___Numbness	___Loss of coordination		
Lungs	___coughing	___wheezing	___shortness of breath	
	___tuberculosis	___spitting up of blood		Last Chest Xray:
Heart	___chest pain	___palpitations	___leg swelling	___shortness of breath with lying down
	___easily fatigue	___sweatiness		
Gastrointestinal		___abdominal pain	___heartburn	___constipation
	___diarrhea	___nausea	___vomitting	___blood in the stool
	___difficulty swallowing			
Urinary	___blood in urine	___infections	___frequent urination	___pain with urination
	___difficulty urinating			
Eyes	___contacts/glasses	___vision changes	___blurry spots	___eye pain
	___excessive tearing			Last Eye Exam:
ENT	___ear drainage	___ringing in the ears		___Recurrent ear infections
	___hearing loss	___sore throat	___nasal drainage	___nasal congestion
	___nose bleeds	___hoarseness	___swelling neck	

Mouth	___dentures	___bleeding gums	___bad breath	Last Dental Exam:
Joints	___Pain	___stiffness	___Decrease movement	___Swelling
Back	___Pain	___stiffness	___deformity (scoliosis)	
Muscles	___Pain	___weakness	___twitching	
Endocrine	___excessive hot	___excessive cold	___always thirsty	___always hungry
Psychological		___depression	___anxiety	___difficult sleeping
	___suicidal	___anger problems	___nightmares	___memory loss
Male	___hernia	___sexual difficulties		___sexually transmitted disease
	___pain in testicles	___discharge from penis		
Female				___vaginal discharge
				___sexually transmitted disease
Number of pregnancy:				___problems during pregnancy
Number of miscarriages:				___lumps in breast
Number of abortions:				___discharge from nipple
Number fo live births:				___problems with menstrual periods
Date of last pap:				___vaginal itching or burning
Date of last mammogram:				___sexually difficulties

Additional Comments:

Member Signature **Date**

Physician Signature **Date**