

Patient Name _____ DOB _____ Date _____

Village Family Practice of Holly Springs
Health History Form

Allergies & Adverse Reactions

Medications *(please include over-the-counter pills, herbs, vitamins, & supplements)*

Name	Dose	#	Frequency	Name	Dose	#	Frequency
<i>Ex: Placebex</i>	<i>50mg</i>	<i>2 pills</i>	<i>twice a day</i>				
1				6			
2				7			
3				8			
4				9			
5				10			
				11			

Past Medical History *(please list any medical problems you can think of)*

(For example: Heart Problems, Diabetes, Hypertension, Cancer, Arthritis, Kidney or Liver trouble, Chronic pain, GERD, Sleep Apnea, Asthma, Emphysema, Thyroid trouble, Migraines, Seizures, and other Chronic Illnesses.)

Surgical History *(please list any operations you have had and the date of the operation)*

Family History *(please list any medical problems in your family and the relationship of the affected family member)*

Other Physicians *(please list your other doctors, their clinic name, and phone number if possible)*

Patient Name _____ DOB _____ Date _____

Patient Name _____ DOB _____ Date _____

Social History

Occupations *(Are you employed? Please list your current and previous occupations)* _____

Where You Are From *(Please list the cities, states, and countries where you have lived the longest)*

Hobbies *(Please list your hobbies and interests and physical activities)*

Habits

Ever smoked? Yes No # of years? _____ Did you quit? Yes No When? _____
Do you drink alcohol? Yes No About how often? every day on weekends occasionally _____

Immunizations – Adult *(Please check all that apply)*

Influenza Date: _____ Pneumonia vaccine Date: _____
 Tetanus booster Date: _____ Shingles vaccine Date: _____

Prior Diagnostic Tests

<input type="checkbox"/> Bone Density Study Date: _____	<input type="checkbox"/> Last Physical Exam Date: _____
<input type="checkbox"/> Cardiac Stress Test Date: _____	<input type="checkbox"/> Mammogram Date: _____
<input type="checkbox"/> CT (“CAT”) Scan Date: _____	<input type="checkbox"/> MRI Date: _____
<input type="checkbox"/> Chest X-ray Date: _____	<input type="checkbox"/> Pap Smear Date: _____
<input type="checkbox"/> Colonoscopy Date: _____	<input type="checkbox"/> Pulm. Function Test Date: _____
<input type="checkbox"/> EKG Date: _____	<input type="checkbox"/> Other Date: _____

Review of Systems *(Please list any symptoms that are a current source of concern)*

General symptoms _____
 Eye, Ear, Nose, or Throat symptoms _____
 Lung symptoms _____
 Heart symptoms _____
 Stomach or Intestinal symptoms _____
 Genital, Urinary, or Menstrual symptoms _____
 Muscle, Bone, or Joint symptoms _____
 Neurological symptoms _____
 Mental or Psychiatric symptoms _____
 Other symptoms _____

How Did You Here About Village Family Practice

Word of mouth Computer search/Website Newspaper Ad
 New Neighbor Welcome Svc Other (please describe) _____