Medical, Family, and Social History Form

Date: ___ / ___ / ____

Patient Information

Name (Last, First, M.I): ____ **DOB:** ___ / ___ / _____

Medical History (Check all that apply):

Kidney Disease:

☐ Chronic Kidney Disease (CKD)
Stage:
O 1
O 2
O 3
O 4
O 5

☐ Dialysis
O Hemodialysis (HD)
O Peritoneal Dialysis (PD)
☐ Kidney Transplant
O Cadaveric
O Living

☐ Bladder Infection
☐ Endometriosis
☐ Kidney Stones
☐ Prostate Enlargement
☐ Prostatitis
☐ Urinary Tract Infection

Diabetes:
O N/A
O Type 1
O Type 2
O Type Unknown

High Blood Pressure: __Yes __ No

Heart Disease: __Yes __No
O Heart Attack
O Coronary Stent
O Angina
O Coronary Artery Bypass Graft
O Angioplasty

Cancer:

O Brain
O Breast
O Bone, Soft Tissue
O Bladder
O Cervical
O Colon
O Endometrial
O Kidney
O Leukemia
O Lung
O Lymphoma
O Melanoma
O Pancreatic
O Prostate
O Skin
O Thyroid
O Other Specific Site
O Unspecified Site

Stroke: __ Yes __ No
Gout: __ Yes __ No
Seizures: __ Yes __ No

Past Medical History – Do you have a personal history of any of the following? (Check ALL that apply)

O Acid Reflux
O Asthma
O Blindness
O Cataracts
O Chronic Bronchitis
O Congestive Heart Failure
O COPD
O Gall Bladder Disease
O Glaucoma
O Gluten Intolerance
O Heart Murmur
O Hearing Problems
O Hepatitis (A / B / C)
O Implanted Defibrillator
O Irritable Bowel Syndrome
O Lactose Intolerance
O Mitral Valve Prolapse (MVP)
O Nerve/Muscular Disease
O Pacemaker
O Pneumonia
O Sleep Apnea
O Stomach Ulcers
O Substance Abuse
O Tuberculosis

Past Medical History Cont. – Do you have a personal history of any of the following? (Check ALL that apply)

O Alcoholism
O Alzheimer's
O Anemia
O Arthritis
O Bleeding Tendency
O Broken Bone(s)
O Burns
O Car Accident
O Concussion
O Deep Vein Thrombosis (DVT)
O Dementia
O Epilepsy
O Hemophilia
O High Cholesterol
O HIV
O Leg Cramping
O Lupus
O Other: ________
O Sexually Active (__Y __N)

Tobacco Use: __Yes __No Cigarettes Pipe Cigars E-Cigs Vaporizer Smokeless (Snuff or Chew)
How many packs per day: ____ how long have you been smoking? ___________

Alcohol Use: __Yes __No Beer Wine Liquor Other
How many drinks per week? __________

Drug Use: __Yes __No what kind? ___________

OB/GYN Past Medical History – Do you have a personal history of any of the following? (Check ALL that apply)

O Birth Control (__Y __N)
O Colposcopy
O Contraceptive Implant Insertion
O C-Section
O Curettage, Post Delivery
O Dilation & Curettage (DNC)
O Ectopic pregnancy
O Gestational Diabetes
O Hysterectomy
O Hysteroscopy
O IUD Insertion
O IUD Removal
O Preeclampsia
O Tubal Ligation

Date of Last PAP Smear __ / __ / __
Date of Last Menstrual Period __ / __ / __
Number of Pregnancies ___
Number of Living Children ___

Surgical History – Have any of the following surgeries been performed on you? (Check ALL that apply)

O Angioplasty
O Appendectomy
O Arthroscopy
O Back/Spine
O Biopsy
O Blood Transfusion
O Cardiac Catheterization __Left __Right
O Chest Tube
O Colonoscopy
O Hip Replacement __Left __Right
O Intracranial Aneurysm
O Kidney Transplant
O Knee Replacement __Left __Right
O Lung Transplant
O Polyp Removal, Colon
O Stent
O Other Cardiac Procedure
O Other ________________________

Other health concerns not listed above:

____
____
____
____
____

The Jane Pauley Community Health Center

MEDICATIONS: (Include over the counter medications)

List of medications	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

____

____

Immunizations:
Date of last Flu vaccine: ___ / ___ / _____
Date of last Pneumonia vaccine: ___ / ___ / _____
Date of last Tetanus shot: ___ / ___ / _____

Child Immunizations:

Attach Immunization History

Family History - Status

Father	**___Living**	**___Not Living**
Deceased:	**Age of Death:____**	**Cause:__________________**
Mother	**___Living**	**___Not Living**
Deceased:	**Age of Death:____**	**Cause:__________________**

Family Medical History – Do any family members have a personal history of any of the following? (Check ALL that apply)

Problem	Mo	Fa	Bro	Sis	MGMo	MGFa	PGMo	PGFa	Son	Dau
Alcohol/Drug Abuse										
Allergies										
Arthritis										
Asthma										
Bleeding/Blood Disorder										
Cancer										
COPD										
Depression										
Diabetes										
Gastrointestinal Problems										
Genetic Diseases/Birth Defects										
Genitourinary Problems										
Headaches										
Heart Problems										
High Cholesterol										
Hypertension										
Kidney Disease										
Mental Illness										
Musculoskeletal Disorders										
Nervous System Disorders										
Obesity										
Osteoporosis										
Sickle Cell Anemia										
Stroke										
Thyroid Disease										
Tuberculosis										
Eye Problems										
Other										