# Lehigh Valley Family Practice Associates

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

**Past Medical History**

Have you ever had:

- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Anxiety
- ☐ Arthritis _____
- ☐ Asthma
- ☐ Atrial Fib
- ☐ Blood clots
- ☐ CAD (Coronary Artery Disease)
- ☐ Cancer _____
- ☐ Cardiac arrhythmia
- ☐ COPD
- ☐ Depression
- ☐ Diabetes _____
- ☐ Elevated lipids
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure/HTN
- ☐ Irritable bowel disease
- ☐ Osteoporosis
- ☐ Seizure Disorder
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Thyroid disease

**Past Diagnostic Testing**

Have you ever had (if so, indicate the most recent date):

- ☐ Cardiac stress test _____
- ☐ Cholesterol screen _____
- ☐ Colonoscopy _____
- ☐ DEXA Scan _____
- ☐ Diabetic eye exam _____
- ☐ Diabetic foot exam _____
- ☐ FOBT (Fecal Occult Blood Test) _____
- ☐ Mammogram _____
- ☐ Pap Smear/Abnormal Pap_____
- ☐ Prostate exam/PSA _____

**Immunization History**

Indicate most recent year vaccinated, if known:

- ☐ Tdap _____
- ☐ Pneumonia vaccine _____
- ☐ Flu vaccine _____
- ☐ Shingles vaccine _____

**Surgical History**

List any surgeries and indicate year:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

**List all medications, herbs, vitamins, or supplements. Attach additional sheet if necessary.**

| Name | Dose | Frequency |
|---|---|---|
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# Lehigh Valley Family Practice Associates

**Medication Allergies:**

_____

**Local Pharmacy Name and Address:**

_____

_____

**Mail Service Pharmacy & Address**

_____

_____

**Personal and Social History**

**Marital Status:** Single / Married / Divorced / Separated / Widowed / Other

**Sexually Active:** Yes / No

**Children:**

# of Daughters_____ DOB _____ _____ _____

# of Sons_____ DOB _____ _____ _____

☐ Who lives with you in your home? _____

☐ Pets in the home? _____

☐ Do you use a seat belt when in a motor vehicle? Yes / No

☐ Exercise Type and Frequency _____

☐ Occupation/Employment_____

☐ Military Experience _____

☐ **Alcohol Use**

Type _____

Frequency _____ drinks per day / month / year

☐ **Tobacco Use**

Type _____ Second Hand Smoke Exposure _____

Frequency _____ packs per day / month / year

Age Started _____ Age Stopped _____

☐ **Drug Use/Abuse**

Type _____

Frequency _____ per day / month / year

Attended Treatment Program: yes / no Where _____ When _____

☐ **Caffeine Use**

Type: coffee / tea / soda / energy drinks / other

Frequency _____ drinks per day / month / year

**Family History**

Mother: Living / Deceased Age of Death _____ Cause of Death _____

Father: Living / Deceased Age of Death _____ Cause of Death _____

Indicate any significant family medical history, such as cancers, heart disease, diabetes, etc.

_____

_____

_____

SIGNATURE _____ DATE_____