CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Physician Office Practices

Personal and Family Health History

Health Problem or Diagnosis Place a check mark in each box that applies	Self	Child	Father	Mother	Sister	Brother	Grandparent	Health Problem or Diagnosis Place a check mark in each box that applies	Self	Child	Father	Mother	Sister	Brother	Grandparent
Behavioral:								**Genitourinary:**							
Alcohol Abuse								Kidney Failure							
Drug Abuse								Kidney Stones							
Eating Disorder								**ENT:**							
Emotional Problems								Ear Infection							
Learning Disability								Hay Fever							
Nerves/Anxiety								Hearing Problems							
Suicide Attempts/Thoughts								Seasonal Allergies							
Violent Behavior								Tinnitus (ear ringing)							
Smoke								**Hematologic:**							
Cardiovascular:								Anemia							
CAD-Coronary Artery Disease								Bleeding Disorder							
HTN-High Blood Pressure								Clotting Disorder							
Heart Disease								Hemolytic Anemia							
Heart Failure								Polycythemia							
Heart Murmur								Sickle Cell Anemia							
High Cholesterol								Sickle Cell Trait							
MI-Heart Attack								**Integumentary:**							
Endocrine/Metabolic:								Eczema							
Diabetes								Psoriasis							
Thyroid Disease								**Infections Disease:**							
Neurologic:								Tuberculosis (TB)							
Alzheimer's Disease								**Respiratory:**							
Cerebral Palsy								Asthma							
Dementia								COPD							
Migraine								**Immunologic:**							
Multiple Sclerosis								AIDS							
Myasthenia Gravis								HIV							
Neuropathy								Immunosuppression							
Numbness/Tingling								Lupus							
Parkinson's Disease								**Psychiatric:**							
Seizures								ADHD (Attention Deficit with Hyperactivity Disorder)							

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Stroke								ADD (Attention Deficit Disorder without Hyperactivity)							
TIA-Transient Ischemic Attack								Anxiety/Panic Attacks							
Tremors								Bipolar							
Weakness								Depression							
Musculoskeletal:								Schizophrenia							
Arthritis								Other Mental Health Disorder-Please describe:____________ __________________________ __________________________							
Osteoporosis															
Rheumatoid Arthritis															

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Oncologic:								**Medical Devices:**							
Brain Tumor								Pacemaker							
Breast Cancer								Defibrillator							
Colon Cancer								Insulin Pump							
Uterine Cancer								Greenfield Filter (IVC)							
Cervical Cancer								Other: (Please list below)							
Ovarian Cancer								**Gynecological**							
Prostate Cancer								Abnormal Pap							
Rectal Cancer								Endometriosis							
Skin Cancer								Fibroids							
Bladder Cancer								Abnormal Uterine Bleeding							
Lung Cancer								Colposcopy							
								LEEP							

Past Surgical History (Self)

Date Performed	Procedure	Date Performed	Procedure

Physician Office Practices

Personal and Family Health History

Use this area to explain any Medical and/or Surgical history that was not included or need further information:

____

____

____

____

Current medication name and dosage:

____

____

____

Are you allergic to any medications? ______No _____Yes If yes, list. _____________________________________

____

Date of last Physical Exam: ________________ Date of last Mammogram (females): _______________

Date of Last Breast and Pelvic Exam (females): _______________

Number of Prior Pregnancies: _______________ Number of Live Births: _______________

Date of Last Prostate Exam (males):_______________

Date of Last Colonoscopy: ______________ Date of Last Bone Density Test: _______________

SOCIAL HISTORY

Do you smoke? ___No ___Yes If yes, how much?__________ Did you ever smoke? ___________

If yes, for how many years? ___________

Number of alcoholic drinks you consume per week? ____________

Do you use street drugs? ___No ___Yes If yes, type ____________

Sexual Preference: ___Men ___Women ___Both

Pharmacy Name:____

Pharmacy Phone: ____

Patient Signature: ____Date:______________ Time: _____________

Patient Name (Printed): ____

Guardian Signature: ____________________________ (if applicable) Date: _____________ Time: ______________

Guardian Name (Printed): ____ (if applicable)

Harnett Health
P.O. Box 1706 Dunn, NC 28335
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