

Davidson Family Medicine

104 Knox Court Suite 100 Davidson, NC 28036

NAME: _____
NICKNAME: _____

DATE: _____
DOB: _____ AGE: _____

Past Medical History

***PLEASE CIRCLE ANY SIGNIFICANT CHRONIC MEDICAL PROBLEM OR SERIOUS ILLNESSES/INJURIES.**

HIGH BLOOD PRESSURE ASTHMA EPILEPSY BLEEDING DISORDER OVERWEIGHT/OBESITY
HIGH CHOLESTEROL HYPOTHYROIDISM STROKE KIDNEY DISEASE CANCER: Type _____
HEART DISEASE DIABETES ARTHRITIS DEPRESSION OTHER _____

HOSPITALIZATIONS/SURGERIES:

YEAR	REASON	HOSPITAL

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES _____ NO _____ IF YES, WHEN? _____

Family History

Relationship	AGE	State of Health	Age at Death	Medical problems/or cause of death
Father				
Mother				
Brothers				
Sisters				

Social History

WHO DO YOU LIVE WITH? _____
MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOW/WIDOWER
CHILDREN? GENDER AND AGES? _____
OCCUPATION? _____
DO YOU EXERCISE? No Occasionally Regularly (Four times a week) What type of Exercises? _____
HEALTH HABITS? ALCOHOL QUANTITY? _____ TOBACCO QUANTITY? _____ CAFFEINE QUANTITY? _____
DO YOU REGULARLY USE RECREATIONAL/STREET DRUGS? _____
DO YOU WISH TO DISCUSS ANY VIOLENCE IN YOUR HOME? YES NO N/A
LANGUAGE PREFERENCE? ENGLISH SPANISH OTHER _____
DO YOU CONSIDER YOUR NUTRITION TO BE ADEQUATE? _____
DO YOU FOLLOW ANY PARTICULAR DIETS? _____

REASON FOR YOUR VISIT TODAY: _____