# AGUILAR FAMILY HEALTH CARE

**HEALTH HISTORY**

**PAST MEDICAL HISTORY:**

☐ None/ Unremarkable
☐ Abnormal Pap Smear
☐ Asthma
☐ Atrial Fibrillation
☐ Anemia
☐ Anxiety
☐ Autoimmune Disorder
☐ Biliary Cirrhosis
☐ Blood Transfusion(s)
☐ Brain Tumor
☐ Breast Cancer
☐ Breast Disease
☐ Cerebrovascular Disease
☐ Cervical Cancer
☐ Cirrhosis
☐ CVA/Stroke
☐ COPD
☐ Colon Cancer
☐ Coronary Heart Disease
☐ Crohn's Disease
☐ CRF
☐ Depression
☐ DES Exposure
☐ Diabetes Gestational
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Diverticulitis
☐ DVT
☐ G I Bleed
☐ GERD
☐ Glaucoma
☐ Hemochromatosis
☐ Hyperlipidemia
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Infertility
☐ Kidney Disease
☐ Kidney Stone
☐ Liver Disease
☐ M I
☐ Neurologic Disorder
☐ Osteoarthritis
☐ Osteoporosis
☐ PVD
☐ PUD
☐ RH Sensitized
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ TAH
☐ TAH w/BSO
☐ Thyroid Disorder
☐ Tuberculosis
☐ Uterine Anomaly
☐ UTI-Recurrent
☐ Valvular Heart Disease
☐ Varicose Veins/Phlebitis
☐ Other_____
☐ Other_____

**PAST SURGICAL HISTORY WITH DATE:**

☐ None/ Unremarkable(DATE)
☐ AbdSurg-Type_____
☐ Amputation_____
☐ AV Fistula Creation_____
☐ AV Graft_____
☐ Aortic Valve Replacement _____
☐ Appendectomy_____
☐ BA-F Bypass_____
☐ Back Surgery_____
☐ Breast Surgery_____
☐ Bronchoscopy_____
☐ CABG_____
☐ Carotid Endarterectomy_____
☐ Carpel Tunnel_____
☐ Cataract Extraction_____
☐ Cholecystectomy_____
☐ Colon Resection_____
☐ Craniotomy_____
☐ Gastric Bypass_____
☐ Hemorrhoidectomy_____
☐ Knee Arthroscopy_____
☐ Knee Replacement_____
☐ Kyphoplasty_____
☐ LA-F Bypass_____
☐ Lumpectomy_____
☐ Mastectomy_____
☐ Mitral Valve Replace_____
☐ Nephrectomy:Native_____
☐ Nephrectomy:Transplant_____
☐ Pacemaker_____
☐ Parathyroidectomy_____
☐ Pneumonectomy_____
☐ PTCA_____
☐ RA-F Bypass_____
☐ Rotator Cuff Repair_____
☐ TAH _____
☐ TAH w/ BSO_____
☐ Tonsillectomy
☐ Tunneled Dialysis Cath_____
☐ U P PP_____
☐ Vertebroplasty_____
☐ Anesthesia Problem- No_____
☐ Anesthesia Problem- Yes_____
☐ Surgical Complications-No____
☐ Surgical Complication-Yes____
☐ Post-Op Delirium_____

PATIENT'S NAME: _____DOB_____ REV 6/9/15

AGUILAR FAMILY HEALTH CARE

# FAMILY HISTORY

**(M) Mother, (F) Father, (B) Brother, (S) Sister, (D) Daughter, (SN) Son,(MGM) Maternal Grandmother,**

**(MGF) Maternal Grandfather,(PGM) Paternal Grandmother, (PGF) Paternal Grandfather**

☐ FH Unknown
☐ FH Alcoholism
☐ FH Anemia
☐ FH Angina
☐ FH Arthritis
☐ FH Anesthetic Complications
☐ FH Anxiety
☐ FH Asthma
☐ FH Birth Defects
☐ FH Bleeding Disease
☐ FH Breast Cancer
☐ FH Cervical Cancer
☐ FH CHD male <55
☐ FH CHD female <55
☐ FH Colon Cancer
☐ FH Depression
☐ FH Endometriosis
☐ FH Glaucoma
☐ FH Growth/Dev Complications
☐ FH Headaches
☐ FH Heart Disease
☐ FH High Cholesterol
☐ FH Kidney Disease
☐ FH Lung Cancer
☐ FH Lung/Respiratory Disease
☐ FH Melanoma
☐ FH Migraines
☐ FH Osteoporosis
☐ FH Ovarian Cancer
☐ FH PMS
☐ FH Psychiatric Care
☐ FH Seizures
☐ FH Severe Allergies
☐ FH Strokes
☐ FH Thyroid Problems
☐ FH Tuberculosis
☐ FH Uterine Cancer
☐ FH Weight Disorder
☐ FH Other Cancer
☐ FH Other Medical Problem

**SOCIAL HISTORY:**

Smoker: ☐ Current ☐ Former ☐ Never ☐ Unknown How many cig. per day/week/month: _____

Passive Smoker: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No Amount per day/week/month: _____

Drug Use: ☐ Yes ☐ No

HIV/High Risk: ☐ Yes ☐ No

Coffee/Tea/Soda Amount per day/week/month: _____

History of Domestic Abuse: ☐ Yes ☐ No

Regular Exercise: ☐ Yes ☐ No

Date of Last Pap Smear: _____

Date of Last Mammogram: _____ Hysterectomy: ☐ Yes ☐ No Date: _____

PATIENT'S NAME: _____DOB_____

Marital Status: _____ Spouse's Name: _____

Children: _____

Your Occupation_____ Religion Affecting Care: ___Yes ___No

**LIST ALL ALLERGIES:** Food/Drug/Environmental Substance: _____

Criticality of Reaction: Critical Reaction/Severe Reaction/Moderate Reaction/ Mild Reaction

Please Describe Reaction: _____

Approximate Onset Date: _____

**LIST ALL MEDICATIONS YOU ARE NOW TAKING:**

MEDICATION NAME STRENGTH HOW OFTEN

_____
_____
_____
_____
_____
_____
_____
_____
_____

**IMMUNIZATION HISTORY AND DATE:**

Hepatitis_____ Tetanus_____ Pneumonia _____ Influenza _____