 **BELLBROOK FAMILY PRACTICE**

 **Medical/Social History Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Todays date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Biological Sex M F Gender Identity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone ( )\_\_\_\_-\_\_\_\_\_\_\_\_

**Allergies**

Please list all Drug, Food, Animal, and Miscellaneous allergies you have. Please indicate the reaction you have had (Hives, Stomach Upset, Itching, etc.)

Allergy Type of Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History**

Please mark the box next to each past or present condition.

High Blood Pressure  High Cholesterol  Autoimmune conditions 

Diabetes  Asthma  Cancer 

Stroke  Emphysema/COPD  Fibromyalgia 

Heart Disease  Liver Disease  Seizures/Epilepsy 

DVT/Pulmonary embolism  GERD/Reflux/Ulcers  Headaches/Migraines 

Heart Murmur  Arthritis/Osteoporosis  Kidney Disease 

Thyroid Disease  Anemia  Tuberculosis 

Gout  Diverticulitis  Irritable Bowel 

Seasonal Allergies  Depression/Anxiety  Menstrual Problems 

Coronary artery Disease  Eye problems  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 

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**Obstetrics History**

Number of Pregnancies \_\_\_\_\_ Actual Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Hysterectomy Yes / No If Yes Date\_\_\_\_/\_\_\_\_/\_\_\_\_

**Surgeries**

Please list any prior surgeries and the date or year if known.

Surgery Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History**

Write in the relationship of any family members who have or had any of the following conditions.

High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease/Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Please circle yes or no, and please fill in the blanks as appropriate.

Tobacco Use? (Cigarettes or Chewing Tobacco.) **YES NO** Packs Per day \_\_\_\_ Number of years \_\_\_\_\_

Former Smoker? **YES NO** Year Quit \_\_\_\_\_

E-Cigarettes? **YES NO**

Alcoholic Beverages **YES NO** How many days in the past year have you had a heavy drinking consumption of 4 or more drinks? \_\_\_\_\_

Recreational Drug Use ? **YES NO** If yes type used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Intake? **YES NO** Drinks per day\_\_\_\_

How may days per week of exercise do you get? \_\_\_\_\_\_

Advanced Directive? **YES NO** **(If yes please provide a copy to our staff)** Code Status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Employed? **YES NO** Occupational Health Hazards? **YES NO** Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

Medication Strength Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

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