THE DOCTOR'S OFFICE
Family Medicine

Peachtree City – E. Coweta – Forest Park – Eagles Landing – Stockbridge – McDonough - Griffin

PATIENT HEALTH HISTORY FORM

HISTORY AND PHYSICAL

Name:	**SS#:**	**Date:**
Address:		**Occupation:**
Phone (home):	**(work):**	
Chief Complaint :		**Date of Birth:**

Drug Allergies

Current Medications

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATIONS OR SURGERIES

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? _____ Yes _____No Planning Pregnancy? _____ Yes _____ No

MEDICAL HISTORY

☐	Headache	☐	Lactose intolerance	☐	Depression
☐	Shortness of breath	☐	Gallbladder disease	☐	Gout
☐	Heart Palpitations	☐	Prostate disease	☐	Stroke
☐	Heart Murmur	☐	Bowel irregularity	☐	Cancer
☐	Chest Pain	☐	Incontinence	☐	Rheumatic Fever
☐	Dizziness/fainting	☐	Sexual/menstrual dysfunction	☐	Glaucoma
☐	Peripheral Vascular Disease	☐	Veneral Disease	☐	Epilepsy/Convulsions
☐	Allergies / hay fever	☐	Diabetes	☐	Bleeding Disorder
☐	Asthma / emphysema	☐	Hepatitis	☐	Kidney disease
☐	Bronchitis	☐	Anemia	☐	Thyroid disease
☐	Pneumonia	☐	Arthritis	☐	Mental Illness
☐	Ulcer	☐	Osteoporosis	☐	**Other (please specify):**
☐	GI disorder	☐	Hypertension (High Blood Pressure)	☐	

HABITS

☐	**Smoke:**	Packs Daily	☐	**Coffee:**	Cups daily	☐	**Sleep:**
		How long	☐	**Other Caffeine:**		☐	Difficulty falling asleep
		When Stopped	☐	**Alcohol:**	Type/amount	☐	Continuity disturbances
☐	**Exercise routine:**		☐	**Diet:**	Salt intake	☐	Snoring
					Fat intake	☐	Early morning awakening
☐	**Contact with blood or body fluid at work:**					☐	Daytime drowsiness