Coffey Health System Physician Clinics
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A division of Coffey Health System

Date:

Patient Last Name: Patient First Name: Date of Birth:

Patient Medical History

AIDS/HIV Positive	Depression	Herpes	Thyroid Disorder
Acne	Diabetes	High Blood Pressure	Tuberculosis
ADD/ADHD	Drug Addiction	High Cholesterol	Tumors or Growths
Allergies	Emphysema	Hypoglycemia	Ulcers
Alzheimer's Disease	Epilepsy/Seizures	Irregular Heartbeat	Venereal Disease
Anemia	Enlarged Prostate	Irritable Bowel Disease	Yellow Juandice
Anxiety	Fracture	Kidney Disease	
Arthritis/Gout	Fainting/Dizziness	Liver Disease	Cancer (list type)
Asthma	Gallbladder Disease	Osteoarthritis	____________
Atrial Fibrillation	Genital Herpes	Osteoporosis	____________
Blood Disorder	Glaucoma	Parathyroid Disease	____________
Concussion	Hay Fever	Renal Disease	____________
Congential Disease	Headaches	Rheumatic Fever	
Convulsions	Hearing Problems	Shingles	Other Illness
Constipation	Heart Attack/Failure	Sickle Cell Disease	____________
COPD	Heart Murmur	Spina Bifida	____________
Crohn's Disease	Hepatitis A/B/C	Stroke	

Family History

Deceased	**Mother**	**Father**	**Sibling**	High Blood	**Mother**	**Father**	**Sibling**
ADD/ADHD	**Mother**	**Father**	**Sibling**	High Cholesterol	**Mother**	**Father**	**Sibling**
Alcoholism	**Mother**	**Father**	**Sibling**	Learning Disability	**Mother**	**Father**	**Sibling**
Allergies	**Mother**	**Father**	**Sibling**	Mental Illness	**Mother**	**Father**	**Sibling**
Alzheimer's Disease	**Mother**	**Father**	**Sibling**	Obesity	**Mother**	**Father**	**Sibling**
Asthma	**Mother**	**Father**	**Sibling**	Renal Disease	**Mother**	**Father**	**Sibling**
Blood Disorder	**Mother**	**Father**	**Sibling**	Seizure Disorder	**Mother**	**Father**	**Sibling**
Depression/Anxiety	**Mother**	**Father**	**Sibling**	Other Illness			
Diabetes	**Mother**	**Father**	**Sibling**				
Hearing Loss	**Mother**	**Father**	**Sibling**				

Surgical History (Please provide the year surgery was performed)

		Females	**Males**
Adenoidectomy	Colostomy		
Angioplasty	Dental Surgery	Breast Biopsy	Prostate Biopsy
Appendectomy	Gallbladder Removed	C-Section	TURP
Back Surgery	Hernia Repair	Hysterectomy	Vasectomy
CABG	Joint Replacement	Tubal Ligation	Other Surgical Procedure
Carpal Tunnel	Tyroidectomy	Mastectomy	
Colonscopy	Tonsillectomy	Oophorectomy	

Medical Status

Chemotherapy	Pacemaker	Heart Valve Replacement	Pregnant

Medication Allergy (*Please list allergy*) ____________________

Immunotherapy	Dialysis	Joint Replacement

Social History

Tobacco Use	Illicit/Street Drug Use	Alcohol Use	Occupation:__________
Type:__________	Years of Use:__________	Drinks per week:______	Marital Status:__________
Years of Use:__________	Type:__________	or	Number of Children
Packs per date:_______		Drinks per year:_______	_________ Deceased _____ Living

Please complete annually.