

# Goppert-Trinity Family Care

Today's Date: \_\_\_\_\_

## PHYSICAL HISTORY

This is a confidential record of your medical record history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name _____	Male or Female	Age _____	Birth date _____
Address _____	City _____	State _____	ZIP _____
Date of last physical examination. ____/____/____		OCCUPATION: _____	
Today's complaint (please list all symptoms)		WEIGHT - Now _____ One year ago _____	
1. _____		WEIGHT -Maximum _____ When _____	
2. _____		Marital status: _____	
3. _____		Drink alcohol? _____ How much: _____	
4. _____		Do you smoke? _____ # of packs per day _____	

<b>I am allergic to these medications:</b> <input type="checkbox"/> Codeine <input type="checkbox"/> Asprin <input type="checkbox"/> Penicillin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Mycins	<b>I have been immunized for:</b> <input type="checkbox"/> Measles <input type="checkbox"/> Pneumonia <input type="checkbox"/> Mumps <input type="checkbox"/> DTP <input type="checkbox"/> Polio <input type="checkbox"/> HiB <input type="checkbox"/> Tetanus <input type="checkbox"/> Rubella <input type="checkbox"/> Mumps <input type="checkbox"/> Other	<b>My food allergies are</b>   
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<b>I am taking the following MEDICATIONS:</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	<b>Surgeries that I have had:</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
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## FAMILY HISTORY

Relationship	Age	Health If Living	Age at Death	Cause of death
Father				
Mother				
Brother or sister, siblings				
1.				
2.				
3.				
Spouse				
Son, daughter, Children				
1.				
2.				
3.				

Has any blood relative had	YES	WHO
Cancer		
Tuberculosis		
Diabetes		
Heart Trouble		
High Blood Pressure		
Stroke		
Birth defects		
Asthma		

Person to contact in case of emergency \_\_\_\_\_ Telephone# \_\_\_\_\_

Turn page over and complete

## Personal History

I have had or have been diagnosed with:

SKIN	YES	NO
Itching		
Easy Bruising		
Changing spots/Lesions		
Easy Bleeding		
<b>LYMPH NODES</b>		
Swelling of "Glands"		
<b>BONES, JOINTS, MUSCLES</b>		
Fractures		
Arthritis		
Stiffness		
Night leg Cramps		
Muscles Aches		
Tumors		
<b>BLOOD</b>		
History of Anemia		
History of Bleeding		
High Blood Pressure		
<b>ENDOCRINE/ GLANDS</b>		
Thyroid problems		
Infertility		
Impotence		
Weakness		
Hair Loss		
Cold or Heat Intolerance		
Skin Changes and/or color		
<b>HEAD</b>		
Headaches, Tension or Migraine		
Loss of Consciousness		
Dizziness		
Seizures, Epilepsy		
Stroke		
<b>EARS</b>		
Hard of Hearing		
Ringing		
<b>GI SYSTEM</b>		
Painful or difficulty swallowing		
Abdominal pain		
Changes in stool		
Use laxatives		
Hemorrhoids		
Constipation		
Heartburn Constant		

EYES	YES	NO
Color Blindness		
Double vision		
Near or Far Sighted		
Visual loss		
Glaucoma		
Retinopathy		
Pain		
<b>NOSE</b>		
Allergies		
Sinus problems		
Nose Bleed		
<b>MOUTH</b>		
Dentures		
Tooth Pain		
Abnormal Sores		
Bleeding		
<b>THROAT</b>		
Hoarseness		
Sore Throat		
Voice changes		
Trouble Swallowing		
<b>LUNGS</b>		
Shortness of breath		
Cough		
Sputum		
Tuberculosis		
Infections/Pneumonia		
Asthma		
<b>HEART</b>		
Fluttering, Irregular rhythm		
Chest Pain		
Murmurs		
<b>GU</b>		
Difficulty urinating		
Burning, pain with urination		
Venereal Disease		
Drug abuse		
Nervous breakdown		
Depression		
Suicide attempt		

QUESTIONS THAT YOU WOULD LIKE TO ASK THE DOCTOR: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_