Hometown Family Medicine, Inc.

Patient Name ______________________________ Date of Birth ____________________

Drug Allergies ☐ No ☐ Yes (if yes, please list below)

Current Medications (list medication & dosage)

Surgical History (surgery & year)

Do you have a medical history of:

Condition	Yes	No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Headaches/Migraines	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Acid Reflux	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No
Liver problems	☐ Yes	☐ No
Colon Cancer	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No

Preventive Screenings (list date)

Colonoscopy ☐ Yes __________ ☐ No
Eye Exam ☐ Yes __________ ☐ No
Dental Cleaning ☐ Yes __________ ☐ No

Immunizations (list date)

Flu ☐ Yes __________ ☐ No
Tetanus ☐ Yes __________ ☐ No
Pneumonia ☐ Yes __________ ☐ No
Shingles ☐ Yes __________ ☐ No

Females

Menstrual Cycle Age of Onset:
Last Menstrual Period:
Number of Pregnancies:
Number of Living Children:
Last Pap Smear date:
Last Mammogram:

Males

Decreased Sexual Desire ☐ Yes ☐ No
Erectile Dysfunction ☐ Yes ☐ No
Last prostate exam:

Social History (list quantity)

Tobacco Use ☐ Yes __________ ☐ No
Caffeine Use ☐ Yes __________ ☐ No
Alcohol Use ☐ Yes __________ ☐ No
Daily Exercise ☐ Yes __________ ☐ No