DOVETAIL Family Practice
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MEDICAL HISTORY

DATE: _____

Patient Name: _____
D.O.B. _____

Your answers on this form will help Dr. S. Hulsemann understand your medical concerns and conditions better. If you are uncomfortable with any question, please do not answer it. Best estimates are fine if you cannot remember specific details.

Thank you!

REASON FOR VISIT: _____
_____
_____

CURRENT MEDICAL ILLNESS OR PROBLEMS: If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician that is treating you for that problem:

ILLNESS OR MEDICAL PROBLEMS	PHYSICIAN TREATING YOU
1)	
2)	
3)	
4)	
5)	

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATION	DOSE	MEDICATION	DOSE
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

ALLERGIES AND SENSITIVITIES: List anything that you are allergic to, such as certain foods, medications, dust, chemicals or soaps, household items, pollen, bee stings, etc., and indicate how each affects you.

ALLERGIES AND SENSITIVITIES	REACTIONS
1)	
2)	
3)	
4)	
5)	

SURGICAL HISTORY: Please list all prior operations with dates and facility names if any. **Please do not include normal pregnancies.**

OPERATION/ ILLNESS	MONTH / YEAR	HOSPITAL NAME / CITY
1)		
2)		
3)		
4)		
5)		

PREGNANCY HISTORY: Please list all pregnancies.

# OF PREG	LIVING	MISCARRIAGES	ABORTIONS	OTHER

FAMILY HISTORY: Please indicate with a check **(√)** family members who have had any of the following medical conditions:

MEDICAL CONDITION	MOM	DAD	SIBLING	GRAND PARENT	CHILD	OTHER
Alcoholism						
Anemia						
Asthma						
Birth Defects / Genetic Diseases						
Cancer **(breast, colon, ovary, prostate, skin)**						
Diabetes						
Epilepsy (seizures)						
Glaucoma						
Heart Attack (coronary artery disease)						
High Blood Pressure (hypertension)						
High Cholesterol (hyperlipidemia)						
Kidney Disease						
Lupus						
Thyroid Disorder						

IMMUNIZATIONS: Please list your most recent immunizations. Please include your best estimate of the month and year for each:

Hep A: _____ Hep B: _____ Tetanus (Td): _____
MMR: _____ Varicella: _____ Pneumovax: _____
Influenza: _____ Other: _____

SOCIAL HISTORY:

SUBSTANCES
Tobacco Use:
Cigarettes
Former / Quit Date: _____
Never
Current: Smoker: packs/day____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? **No Yes**

Alcohol Use:
Do you drink alcohol? **No Yes (**If yes # drinks/week_____
Is alcohol use a concern for you or others? **No Yes**

Drug Use:
Do you use any recreational drugs? **No Yes** (if yes please list): _____
_____

EXERCISE:
Do you exercise regularly? **No Yes**

SOCIOECONOMICS:
Occupation: _____
Education completed: **Grade school High school College Graduate school**
Years of education: _____
Marital status: **S M D W Co-habiting Other**: _____
Spouse/Partner's name: _____
Number of children: _____
Who lives at home with you? _____

SAFETY:
Do use seat-belts consistently? **No Yes**
Do you use a bike helmet regularly? **NA No Yes**
Is violence at home a concern for you? **No Yes**
Do you feel safe in your current relationship? **NA No Yes**
Do you have a gun in your home? **No Yes**
Other concerns? _____

*_____ _____
PATIENT / LEGAL GUARDIAN SIGNATURE **DATE**

*_____ _____
PHYSICIAN SIGNATURE **DATE**