CIAMPI FAMILY PRACTICE
CONFIDENTIAL HISTORY

_____ _____
Last Name First Name M.I. Prefix/Suffix Date of Birth

MEDICAL CONDITIONS: Please circle or list any medical conditions you have: (i.e.: Diabetes, High Blood Pressure, Heart Disease, Migraines, Kidney Problems, Cancer, Arthritis, etc) Please provide dates began, if known, and any comments about the condition. If you see a specialist for it, please list name

MEDICAL CONDITION	DATE DIAGNOSED	COMMENTS (and specialist name if applicable)

SURGICAL HISTORY: Please list all surgeries/operations you have had: (i.e.; appendectomy, tonsillectomy, gall bladder removal, hysterectomy, knee replacements, etc.) Include dates, hospital, and surgeon if known.

DATE	SURGERY	HOSPITAL	SURGEON

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OTHER HOSPITALIZATIONS: Please list any other overnight hospital stays you have had: (i.e.: childbirth, pneumonia, psychiatric hospitalizations, etc.) Include reason for admission, dates, and hospital, if known.

DATE	REASON FOR ADMISSION	HOSPITAL

MEDICATIONS: Please list all medications that you take. Please include prescription drugs, OTC medications, vitamins, and supplements. Also include medication dose, number of pills taken, and how often:

MEDICATION	STRENGTH	NUMBER OF PILLS	HOW OFTEN

ALLERGIES: Please list allergies to medications, foods, and other substances. Please indicate what your reaction was. (i.e.; Penicillin →Hives, Cats→Wheezing)

MEDICATION/SUBSTANCE	REACTION

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SOCIAL HISTORY:

TOBACCO:

Cigarettes: ___never smoked
___quit (please list packs per day, how many years, and date you quit) _____
___currently smoking (please list packs per day and when you started) _____

Cigars: ___never smoked
___quit (please list cigars per day or week, how many years, and date you quit) _____
___currently smoking (please list cigars per day or week and when you started) _____

Pipe: ___never smoked
___quit (please list how many years, and date you quit) _____
___currently smoking (please list times per day and when you started) _____

Chew: ___never used
___quit (please list cans per day, how many years, and date you quit) _____
___currently chewing (please list cans per day and when you started) _____

ALCOHOL: Please describe your alcohol use: (one drink= 12 oz. beer, 4 oz. wine, or 1 shot liquor)

___never drank
___quit drinking alcohol (please list drinks per day and date you quit) _____
___currently drink alcohol
very rarely occasionally socially regularly (circle)
Number of drinks_____ per day week month year (circle)

Are you or anyone close to you concerned about how much you drink? ___ No ___ Yes

DRUGS: (Please describe your use of mind altering drugs, including type [marijuana, cocaine, pills not prescribed to you, ecstasy, etc.] and how much, and provide details.) ***Please be honest. We ask for medical reasons. This is confidential.***

___never used
___quit (please list types of drugs, how many years, and when you quit)

___currently using (please list types of drugs, when you started, and how often you use)

Are you or anyone close to you concerned about your drug use? ___ No ___ Yes

CAFFEINE: (Please describe how much caffeine you consume, including coffee, tea, sodas, etc.)

Coffee:	_____ cups	per	day	week	(circle)
Tea:	_____ cups	per	day	week	(circle)
Soda:	_____ cans/btls	per	day	week	(circle)
Energy Drinks:	_____ cans/shots	per	day	week	(circle)

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DIET: Please describe your usual dietary intake:

Starchy Foods (pasta, breads, potatoes)	___ high	___ medium	___ low	___ none
Sweets (candy, pastries, doughnuts)	___ high	___ medium	___ low	___ none
Fatty Foods (bacon, sausage, fried foods)	___ high	___ medium	___ low	___ none
Fruits	___ high	___ medium	___ low	___ none
Vegetables	___ high	___ medium	___ low	___ none
Dairy (milk, cheese, yogurt)	___ high	___ medium	___ low	___ none
Lean Meats (fish, chicken)	___ high	___ medium	___ low	___ none

Are there any foods you do not tolerate, or try to avoid? (i.e.: gluten, lactose, etc.)
_____

Are you currently trying to lose weight, or are you considering it? ___ no __ yes (currently)
__ yes (considering)

EXERCISE:

Do you exercise regularly? __ Yes __ No

If so, what type and how often? _____

WORK:

Are you currently working/going to school? Please circle:

Yes, Full Time ◆ Yes, Part Time ◆ No, Retired ◆ No, Unemployed ◆ No, Disabled ◆ No, other:

Please describe current occupation/vocation: (Where and what you do)

Are you now, or have you in the past been exposed to hazards? (i.e.: asbestos, toxic chemicals, fumes, radiation, etc.)
__ No __Yes (past) __Yes (currently) If Yes, Please describe what and when:

MILITARY SERVICE:

Have you ever served in the military? __ No __ Yes, in past __ Yes, currently

If so, THANK YOU FOR YOUR SERVICE. Please describe service (branch, time in service, foreign posts, combat or other injuries and disabilities):

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RELATIONSHIP HISTORY:

Please describe current status: (circle) single married committed relationship divorced separated widowed

Sexual Activity: (circle) currently active never active not currently active

If sexually active, do you use birth control? If so, method: _____

Do you feel safe in your current relationship? yes no N/A

FAMILY HISTORY: Please complete to the best of your ability.

RELATIONSHIP	M or F	living?	year of birth	MEDICAL PROBLEMS	AGE OF DEATH	CAUSE OF DEATH (IF APPLICABLE)
MOTHER	F					
FATHER	M					
Mat. GM	F					
Mat. GF	M					
Pat. GM	F					
Pat. GF	M					
SIBLINGS:						
CHILDREN						
OTHER SIGNIFICANT FAMILY HISTORY						

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REVIEW OF SYSTEMS: Please circle any problems or symptoms you are having.

GENERAL: fever ◆ chills ◆ fatigue ◆ weight loss ◆ weight gain ◆ other:

EYES: blurred vision ◆ double vision ◆ watery eyes ◆ blindness ◆ eye pain ◆ other:

EARS: decreased hearing ◆ clogged ears ◆ ear pain ◆ ringing ◆ dizziness ◆ ear discharge ◆ other:
NOSE/SINUS: runny nose ◆ sinus congestion ◆ sinus pain ◆ bloody nose ◆ sneezing ◆ other:
MOUTH: dental problems ◆ cold sores ◆ tongue problems ◆ mouth/jaw pain ◆ other:
THROAT: sore throat ◆ post nasa drip ◆ painful swallowing ◆ burning in throat ◆ enlarged tonsils ◆ other:

RESPIRATORY: shortness of breath ◆ wheezing ◆ coughing ◆ asthma ◆ COPD ◆ other:

CARDIOVASCULAR: chest pain ◆ heart failure ◆ palpitations ◆ heart murmur ◆ aneurysms
high blood pressure ◆ lightheadedness ◆ swollen ankles ◆ cold hands and feet
leg cramping with walking ◆ anemia ◆ varicose veins ◆ other:

DIGESTIVE: decreased appetite ◆ difficulty swallowing ◆ heartburn ◆ stomach upset ◆ abdominal pain
nausea ◆ vomiting ◆ diarrhea ◆ constipation ◆ bloody bowel movements ◆ black bowel movements
hemorrhoids ◆ liver problems ◆ jaundice ◆ other:

KIDNEY: frequent urination ◆ painful urination ◆ blood in urine ◆ kidney stones ◆ kidney failure
difficulty passing urine ◆ waking at night to urinate often ◆ other:

GENITAL (WOMEN): painful periods ◆ heavy periods ◆ irregular periods ◆ painful intercourse
sexual difficulties ◆ vaginal dryness ◆ ovarian cysts ◆ fibroids ◆ difficulty getting pregnant ◆ PMS
endometriosis ◆ breast pain ◆ breast lumps ◆ nipple discharge ◆ other:

GENITAL (MEN): lump in testicles/scrotum ◆ pain in testicles/scrotum ◆ sexual difficulties
prostate problems ◆ difficulty with fertility ◆ other:

ENDOCRINE/GLANDS: intolerance to heat ◆ intolerance to cold ◆ thyroid problems
adrenal gland problems ◆ menopause issues ◆ ow testosterone ◆ hair loss ◆ other:

SKIN: moles ◆ acne ◆ skin lumps/bumps ◆ eczema ◆ psoriasis ◆ skin cancers ◆ dry skin ◆ oily skin
rash ◆ nail problems ◆ hair problems ◆ itching ◆ other:

MUSCULOSKELETAL: back pain ◆ neck pain ◆ shoulder pain ◆ elbow pain ◆ wrist pain ◆ hand pain
hip pain ◆ knee pain ◆ ankle pain ◆ foot pain ◆ arthritis ◆ muscle pain ◆ gout ◆ other:

IMMUNE SYSTEM: frequent illness ◆ allergies ◆ swollen glands ◆ autoimmune disease ◆ HIV
rheumatoid arthritis ◆ Lyme Disease ◆ other:

NEUROLOGIC: headaches ◆ passing out ◆ stroke ◆ memory problems ◆ seizures ◆ confusion
muscle weakness ◆ lack of coordination ◆ difficulty walking ◆ decreased sensation ◆ tremors
attention problems ◆ nerve pain ◆ other:

PSYCHOLOGICAL: anxiety ◆ depression ◆ obsessive/compulsive disorder ◆ mania ◆ insomnia
stress ◆ sadness ◆ seasonal affective disorder ◆ suicidal thoughts ◆ other: