SALINAS FAMILY PRACTICE

1328 Natividad Road * Salinas, CA 93906 * Ph (831) 757-8081 * Fax (831) 757-0625

HISTORY

Name_____ SS#_____ - _____ - _____ Date_____

Address_____ City/St_____ Zip_____ Occupation _____

Phone (home)_____ (work)_____ Date of Birth_____ Age_____

(cell)_____

Main Problem(s):_____

_____

Current Medications: Please bring list to appointment

_____

_____

_____

_____

_____

Allergies: Meds or Environmental_____

_____

_____

_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History

☐ Chest pain_____ ☐ Headaches_____ ☐ Frequent urination_____ ☐ Chicken Pox_____

☐ Irregular heart beat/palpitations_ ☐ Anemia_____ ☐ Loss of urine (Incontinence) ☐ Other_____

☐ Heart Murmur_____ ☐ Depression_____ ☐ Erection Difficulties_____

☐ Circulation problem_____ ☐ Anxiety_____ ☐ Sexually Transmitted Disease_

☐ Dizziness/Fainting_____ ☐ Arthritis/Joint problems_____ ☐ Menstrual problems_____

☐ Shortness of breath_____ ☐ Osteoporosis_____ ☐ Prostate problems_____

☐ Pneumonia_____ ☐ Gout_____ ☐ Frequent infections_____

☐ Asthma_____ ☐ Hepatitis_____ ☐ Rheumatic fever_____

☐ Chronic bronchitis_____ ☐ Constipation/Diarrhea_____ ☐ Measles_____

☐ Allergies/Hay fever_____ ☐ Blood in stools_____ ☐ Mumps_____

☐ Eczema/chronic rashes_____ ☐ Stomach problems/heartburn/ulcer__ ☐ Rubella_____

Women Only:
Last Menstrual Period
_____
Last Pap_____
Where done?_____
Pregnant? ☐ Yes ☐ No
Planning Pregnancy?
☐ Yes ☐ No

Immunizations

Date of Last: Tetanus/Pertussis _____ MMR_____ Zoster (shingles) _____ Pneumonia Vaccine _____

-Please bring Immunization card to appointment

Habits

Smoke: Packs daily_____
How long?_____
Interested in stopping?____

Exercise routine:_____

_____

_____

Coffee: Cups daily_____
Other caffeine_____

Alcohol: Type_____
Amount_____

Diet: Salt intake_____
Fat intake_____

Sleep: Difficulty falling asleep_____
Difficulty staying asleep_____
Snoring_____
Early morning awakening_____
Daytime drowsiness_____
Other_____