Fredericksburg Christian Health Center

Date: ________________

Name: ______________________________________ DOB: _________________________

PAST MEDICAL HISTORY

1. Check any of the following you have or have had and then explain, if necessary, on the lines below.

❒AIDS
❒Allergies
❒Anemia
❒Arthritis
❒Asthma
❒Cancer
❒Constipation
❒Depression
❒Drug/Alcohol Problems
❒Diarrhea
❒Diabetes
❒Glaucoma
❒Heart Disease
❒High Blood Pressure
❒Kidney Disease
❒Lung Disease
❒Mental Illness
❒Pneumonia
❒Seizures
❒Stomach/Bowel Problems
❒Thyroid Disease
❒Tuberculosis

Please explain (include dates, if applicable):__________
____
____
____
____
____

2. List any **HOSPITALIZATIONS or OPERATIONS**:

Date	Hospitalization or Operation
______	________________________________
______	________________________________
______	________________________________
______	________________________________
______	________________________________

3. When was your last TETANUS SHOT? Date_______
Pneumonia shot? Date________

FAMILY HISTORY

Check any of the following if blood relatives – mother(M), Father(F), brother or sister(B or S), aunt or uncle(A or U), or grandparent(GP) – were affected.

ILLNESS	ONE'S AFFECTED	ILLNESS	ONE'S AFFECTED
❒Allergies	__________	❒Heart Disease	__________
❒Anemia	__________	❒High Blood Pressure	__________
❒Arthritis	__________	❒Kidney Disease	__________
❒Asthma	__________	❒Lung Disease	__________
❒Cancer	__________	❒Stomach/Bowel Problems	__________
❒Depression	__________	❒Stroke	__________
❒Diabetes	__________	❒Thyroid Disease	__________
❒Drug/Alcohol Problems	__________		

❒Other Significant Illnesses __________________________

SOCIAL HISTORY

1. Do you smoke? (circle) NO YES
   If **yes**: How much? _______packs/day
   How long have you smoked for? __________years
   If **no**: Were you *ever* a smoker? NO YES ➔ How Long_____
   Quit date_____________

2. Do you drink alcohol? NO YES
   If **yes**: a) how often? Daily Few Times/week Few Times/month Few Times/year
   b) Do you ever feel the need to cut down? NO YES
   c) Does anyone nag you about your drinking? NO YES

3. Who do you live with? (List name and relation)

Name	Relation	Name	Relation
__________ -	_________	__________ -	_________
__________ -	_________	__________ -	_________
__________ -	_________	__________ -	_________

4. What kind of work do you do?__________________________

5. What kind of exercise do you do?_______________________
   How often?_____________________________________

6. Any special diet? (e.g., low fat, vegetarian, etc.)
   (specify)_______________________________________

7. How much caffeine do you drink?_______________________

8. Do you feel safe in your home environment?______________

SPIRITUAL HISTORY

1. How important is God or spirituality to you?
   Very / Somewhat / Not very
2. Do you attend religious services regularly?
   NO YES ➔ how often?________________________
3. Do you pray? NO YES
4. Would you like your doctor to pray with you? NO YES

Drug Allergies:____________________________________

Current Medications:_________________________________
____
____

PLEASE ALSO COMPLETE THE REVERSE SIDE➔➔➔

Reviewed ________________

Name______________________
Date________________________

REVIEW OF SYSTEMS

Check if you've had any of the following recurrent or recent (last two months) symptoms:

- ❒Weight Loss
- ❒Weight Gain
- ❒Fever for more than 2 days
- ❒Headaches
- ❒Dizziness
- ❒Ear Pain
- ❒Hearing Loss
- ❒Blurred Vision
- ❒Nasal Congestion
- ❒Sore Throat
- ❒Hoarseness
- ❒Trouble Swallowing
- ❒Swollen Lymph Nodes
- ❒Breast Pain/Lumps
- ❒Cough
- ❒Difficulty Breathing
- ❒Chest Pain/Pressure
- ❒Indigestion
- ❒Nausea/Vomiting
- ❒Constipation
- ❒Diarrhea
- ❒Hemorrhoids
- ❒Blood in Stools
- ❒Abdominal Pain
- ❒Frequent Urination
- ❒Burning with Urination
- ❒Difficult Starting or Stopping Urine Stream
- ❒Inability to Control Bowel or Bladder
- ❒Sexual Difficulties
- ❒Back Pain
- ❒Arthritis/Joint Pain
- ❒Easy Bruising/Bleeding
- ❒Tremors
- ❒Seizures
- ❒Weakness
- ❒Numbness
- ❒Fatigue
- ❒Memory Loss
- ❒Mood Swings/Depression
- ❒Anxiety
- ❒Unusual Moles/Bumps
- ❒Dry Skin
- ❒Excessive Sweating
- ❒Excessive Thirst

Reviewed:

_____________ ____________

_____________ ____________