Healthy Family Services OF Texas

Medical History Form

Patient Name: _____ DOB:_____

Allergies:_____

Past Medical History: Please check all that apply

ADD/ADHD		COPD/Emphysema		HIV/AIDS	
Alcohol/Drug Addiction		Depression		Iron Deficiency	
Allergies		Diabetes		Kidney Disease	
AIDS/HIV		Emphysema		Kidney Stones	
Anemia		Fatty Liver		Lupus	
Anxiety		GERD		Migraines	
Asthma		Glaucoma		Osteoporosis	
Back Problems		Hearing Loss		Seizures	
Bipolar Disorder		Heart Attack		Sleep Apnea	
Cancer (type_____)		Hepatitis		Stroke	
Clotting Disorder		High Blood Pressure		Thyroid Disease	
Congestive Heart Disease		High Cholesterol		Vertigo	

Medication	Dosage	Times/ Day

Other: _____

Women Only: Number of vaginal births: _____ Number of C-sections_____ Number of miscarriages_____

History of Abnormal Pap Smear? ☐ No ☐ Yes (year_____) History of HPV? ☐ No ☐ Yes

Have you had any of the following procedures? ☐ Colposcopy ☐ Cryotherapy ☐ LEEP ☐ Tubal ligation ☐ Hysterectomy ☐ Ablation ☐ Fibroid removal ☐ Other gyn procedure _____

Date of last cycle: _____. How often do you have your cycle?_____ How long does it typically last?_____

Type of Birth Control : ☐ None ☐ Birth Control Pills ☐ Nexplanon ☐ IUD ☐ Depo ☐ Other:_____

Past Surgical History: If you have had any of the following, please give the year the procedure was performed:

Removal of Tonsils		Removal of Gall Bladder		Kidney Stone Removal	
Removal of Adenoids		Removal of Skin Cancer		Low Back Surgery	
Removal of Appendix		Ear Tubes		Neck Surgery	
Removal of Uterus		Heart Stent		Pacemaker/Defibrillator	
Removal of Ovaries		Heart Bypass Surgery		Vasectomy	

Please list dates of any other surgeries, hospitalizations or major illnesses: _____

Revised 10/2024

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_____

Family History: Please list which family members have the following medical history:

Alcohol/Drug Addition		Diabetes		High Cholesterol	
Anxiety		Epilepsy/Seizures		Kidney Disease	
Arthritis		GI/Bowel Disease		Liver Disease	
Asthma		Glaucoma		Stroke	
Dementia		Heart Disease/Attack		Thyroid Disease	
Depression		High Blood Pressure		Cancer (type_____)	

Other: _____

Father: ☐Living ☐Deceased (age: _____ cause of death: _____)

Mother: ☐Living ☐Deceased (age: _____ cause of death: _____)

Social History:

☐Non-smoker/Never smoked

☐Current smoker: How long does a pack last? _____ days. How many years have you been smoking? _____

☐Past Smoker: What year did you quit? _____ How many years did you smoke for? _____ How much did you smoke? _____

Do you Vape? ☐No ☐Yes If yes, how often? _____

How often do you have alcohol? _____

Do you currently use any drugs? ☐ No ☐ Marijuana ☐ Other : _____

Health Maintenance: Please specify the dates of your most recent health screenings.

Screening	Year	Screening	Year
Physical Exam		Heart Stress Test	
Pap Smear		Bone density scan	
Prostate check		Flu shot	
Colonoscopy		Pneumonia vaccine	
Mammogram		Tetanus Vaccine	
Breast Exam		Shingles Vaccine	
Foot Exam (Diabetics)		HPV Vaccine	
Eye Exam		Teeth Cleaning	

_____ _____

Patient/Parent or Legal Guardian Signature Date

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