RANCHO PASEO MEDICAL GROUP
Total Family Care

Health History Form

Patient name: _____ Date of Birth: __/__/__

Personal & Family Medical History *(Please checkmark all that apply.)*

Alcohol/Drug Dependency	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Anemia	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Anxiety/Depression	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Asthma/Lung Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Blood Clots	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Blood Transfusions	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Cancer	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Coronary Artery Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Diabetes	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Genetic Disease or Birth Defects	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
High Blood Pressure	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
High Cholesterol	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
HIV	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Kidney Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Liver Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Lupus/Arthritis Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Migraines/Headaches	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Multiple Sclerosis	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Seizures	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Stroke	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Stomach Problems	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Thyroid Disease	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____
Tuberculosis	□ self	□ mother	□ father	□ sister	□ brother	□ other: _____

Please list any other medical conditions that are you or your family member has been diagnosed with that is not noted above:

_____

_____

_____

Social History

Sexually Active: □ No □ Yes: Any contraception: □ None □ Birth-Control Pill □ Condom □ IUD □ Implant

Exercise: □ No □ Yes: How many times per week & for how long: _____

Caffeine Use: □ No □ Yes: How many cups per day/per week: _____ Quit Date: _____

Drug Use: □ No □ Yes: How many times per day/per week: _____ Quit Date: _____

Alcohol Use: □ No □ Yes: How many drink per day/per week: _____ Quit Date: _____

Have you ever felt you should cut down on your drinking: □ Yes □ No

Tobacco Use: □ No □ Yes: How many per day/per week: _____ Quit Date: _____

Are you interested in quitting: □ Yes □ No