Wheaton Franciscan Healthcare

PATIENT AND FAMILY MEDICAL HISTORY

Patient Name_____ Date of Birth_____

Please mark for each answer and list the family member(s), where applicable.
****Family includes children, parents, grandparents & siblings. Please identify which side of the family maternal or paternal.***

Cardiovascular		**Age of Onset**
Coronary Artery Disease	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Heart Disease	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
High Cholesterol	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
High Blood Pressure	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Heart Attack	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Sudden Death	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Endocrine/Metabolic		
Diabetes Mellitus (Type 1/2, Gest.)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Thyroid Disorder (Hyper/Hypoactive, Goiter)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Eyes, Ears, Nose and Throat		
Glaucoma	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Hearing Loss	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Vision Loss	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Genetic/Birth Defects		
Birth Defects	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Genitourinary		
Endometriosis	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Kidney Problems	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Polycystic Ovary Disease	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Toxemia of Pregnancy	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Hematologic (Blood)		
Bleeding Disorder (Clotting Disorder, etc.)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Deep Vein Thrombosis (Blood Clots)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Hematologic Disorder (Anemia, Leukemia, etc.)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Hemophilia	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Sickle Cell Anemia	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Mental Health/Substance Abuse		
Alcoholism	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Attention Deficit Disorder	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Bipolar Disorder	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Depression	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Mental Disorder	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Schizophrenia	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Smoking Tobacco	❒ N/A ❒ Self ❒ Family: Relationship_____	_____

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Musculoskeletal		**Age of Onset**
Osteoarthritis	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Osteoporosis	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Other Inflammatory Disorders (Gout, etc.)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Rheumatoid Arthritis	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Rheumatologic Disorder	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Lupus	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Neurologic		
Alzheimer's Disease	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Dementia	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Migraines	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Stroke	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Oncologic (Cancer)		
Breast Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Colorectal Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Endometrial Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Lung Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Melanoma	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Ovarian Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Prostate Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Skin Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Stomach Cancer	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Cancer-Other	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Respiratory		
Asthma	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Pulmonary Embolism	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Respiratory Disorder (COPD, CHF, etc.)	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Smoke Tobacco/Cigarettes	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Tuberculosis	❒ N/A ❒ Self ❒ Family: Relationship_____	_____
Other		
Are You Adopted?	❒ Yes ❒ No	
Other (*please describe*):		
Additional Family History:		
Past Surgical Procedures (include date or age of procedure):		
Advance Directive on File: ❒ Yes ❒ No Date: Where: Pamphlet Given: ❒ Yes ❒ No		

PATIENT SOCIAL HISTORY

Patient Name_____ Date of Birth_____

Please answer each question.

Tobacco
Do you have an exposure to envirnomental smoke: ❒ Yes ❒ No
Are there any household smokers interested in quitting: ❒ Yes ❒ No
❒ Never Smoked ❒ Non-smoker ❒ Current Smoker
Smoking
Type: ❒ Cigarette ❒ Cigar ❒ Pipe
Start Date (number of years):
Amount of Cigarettes (packs per day):
❒ Trivial (less than one cigarette/day) ❒ Light (1 - 9 cigarettes/day) ❒ Moderate (10 -19 cigarettes/day)
❒ Heavy (20 -39 cigarettes/day) ❒ Very Heavy (40+ cigarettes/day)
Interested in quitting: ❒ Yes ❒ No
Smoking Comments:
Smokeless
❒ Former Smokeless User ❒ Current Smokeless User
Type: ❒ Chew ❒ Snuff ❒ Powder
Start Date (number of years): Amount:
Interested in quitting: ❒ Yes ❒ No
Stop Date:
Smokeless Comments:
Alcohol Use
Are you a: ❒ Non-Drinker ❒ Current Alcohol User
Type: ❒ Beer ❒ Hard Liquor ❒ Wine
Average Drinks/Week: Average Drinks/Day:
Do you have a past heavy use of alcohol: ❒ Yes ❒ No
Have you ever been in an alcohol treatment program: ❒ Yes ❒ No
Caffeine Use
❒ No Caffeine Use ❒ Use Caffeine
Type: ❒ Coffee ❒ Tea ❒ Soda/Pop ❒ Energy Drinks ❒ Caffeine Supplements
Total Amount:
Cancer Environmental Risk
Do you have known environmental risk factors for cancer: ❒ Yes ❒ No
Do you use sun protection consistently: ❒ Yes ❒ No
Do you have a history of excessive sun exposure (blistering sunburns): ❒ Yes ❒ No
Do you have a high risk for abnormal skin growth/changes: ❒ Yes ❒ No
Do you have a history of radiation exposure to your neck: ❒ Yes ❒ No
Diet/Nutrition
Type: ❒ Good ❒ Average ❒ Poor
Do you have a diet high in fats: ❒ Yes ❒ No
Not currently limiting calorie intake : ❒ Yes ❒ No
Do you have any difficulty in chewing: ❒ Yes ❒ No
Do you have any difficulty in swallowing: ❒ Yes ❒ No
Do you have a history of an eating disorder: ❒ Yes ❒ No
Do you have any financial issues affecting the ability to buy the necessary food: ❒ Yes ❒ No
Diet Specifics:
Special Diet: ❒ Diabetic ❒ Gluten Free ❒ Low Fat ❒ Low Sodium ❒ Renal ❒ Vegan ❒ Vegetarian ❒ Weight Reduction ❒ Other

PATIENT SOCIAL HISTORY

Patient Name_____ Date of Birth_____

Please answer each question.

Drug Misuse
❒ No reported History of Drug Use ❒ Past Drug User ❒ Current Drug User
Drug Type(s): ❒ Amphetamines ❒ Cocaine ❒ Marijuana
❒ Opiates ❒ Polydrug Usage ❒ Prescription
❒ Other:
Have you used needles to inject drugs: ❒ Yes ❒ No
Pattern of use:
Have you ever been in a drug treatment program: ❒ Yes ❒ No
Do you have a current pain management contract: ❒ Yes ❒ No
Exercise
Do you participate in an aerobic exercise activity: ❒ Yes ❒ No
❒ 5 or more days/week ❒ 3-4 days/week ❒ 2-3 days/week ❒ 1-2 days/week ❒ Sedentary
Average minutes/day: Intensity Level: ❒ Low ❒ Moderate ❒ High
Comments:
Do you participate in resistance training: ❒ Yes ❒ No
Days/Week: Intensity Level:
Comments:
Do you participate in balance training: ❒ Yes ❒ No
Average minutes/day: Intensity Level: ❒ Low ❒ Moderate ❒ High
Comments:
Home Safety Risk
Do you have significant home safety risk factors ❒ Yes ❒ No
Do you live in an abusive home environment: ❒ Yes ❒ No
Do you wear your seat belt consistently: ❒ Yes ❒ No
Do you have smoke detectors in your home: ❒ Yes ❒ No
Do you use proper child safety seat use: ❒ Yes ❒ No ❒ NA
Do you wear a helmet (when necessary) consistently: ❒ Yes ❒ No
Do you have a lead exposure risk: ❒ Yes ❒ No
Are you a fall risk: ❒ Yes ❒ No
Do you know how to swim: ❒ Yes ❒ No
Infectious Exposure Risk
Do you have significant infectious disease risk factors ❒ Yes ❒ No
Infectious Exposure toTuberculosis: ❒ Yes ❒ No
Infectious Exposure to HIV: ❒ Yes ❒ No
Blood Product Exposure: ❒ Yes ❒ No
Blood Product Exposure Year:
Travel Abroad: ❒ Yes ❒ No
Travel Details:
Occupational Safety
Job Description:
Are you satisfied with your job: ❒ Yes ❒ No
Risk Type: ❒ Biologic Agents ❒ Dust ❒ Injury
❒ Toxins ❒ Pesticides ❒ Radiation ❒ Loud Noises
Do you use protective equipment: ❒ Yes ❒ No
Sexual Activity
Are you: ❒ Sexually Active ❒ Not Sexually Active
Do you have high risk sexual behavior: ❒ Yes ❒ No