Name _____

DOB _____

ALBANY FAMILY PRACTICE
INITIAL HISTORY SHEET

Name:	Date of Birth:
Occupation/ Employer:	Highest Level of Education:
Marital Status: M S D W	Living Arrangement:
Reason for Visit:	

Previous hospitalizations, injuries, major illness, surgeries (Do Not Include Normal Pregnancies)

Year	Hospitalization, injuries, illness, surgery	Year	Hospitalization, injuries, illness, surgery

Past Medical & Family History — Please check if you (SELF) or any blood relative (FAMILY) had any of the following conditions:

CONDITION	SELF	FAMILY	CONDITION	SELF	FAMILY
Recent Weight Loss			Kidney/Bladder		
Migraine Headaches			Neurological		
Epilepsy/Convulsions			Arthritis		
Eye Disease (other than glasses)			Osteoporosis		
Hearing Disorder			Cancer – Type:		
Recurrent Nose Bleeds					
Sinus/Throat (Infection(s)					
Angina/Chest Pain			Psychiatric		
Heart Attack			Bleeding Disorder		
High Blood Pressure			Blood Transfusion(s)		
Heart Valve Disorder			Anemia		
Lung Disease			Diabetes		
Stomach Ulcer			Alcohol or Drug Abuse		
Bowel Problems					
Liver Hepatitis			Depression		

DRUG ALLERGIES		DO YOU NOW OR HAVE YOU EVER CONSUMED?			LAST TIME YOU HAD A (YEAR):	
Drug	Reaction	Cigarettes Y N Pks/Day ___ # of Years ___			Flu Vaccine	Tetanus Shot
		Alcohol Y N	Drinks/Wk		Hepatitis Vaccine	Pneumonia Shot
		Coffee/Tea Y N	Cups/Day		TB Test	Rectal Exam
		Street/Legal Drugs Y N			Sigmoidoscopy	Colonoscopy
		Type:			Eye Exam	Dental Exam
					Cholesterol Test	Result

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INITIAL HISTORY SHEET
PAGE TWO

LIST ALL MEDICATIONS YOU TAKE		
Medication	**Dose**	**Frequency**

Do you have any other problems for which you have been seeing a doctor on a regular basis? ***Please List:***

Are you having any symptoms that you would like to discuss? ***Please List:***

FOR WOMEN ONLY		*DO YOU USE?*		
Date of Last Menstrual Period?	**Year of Last:**	**Seat Belts**	**Y**	**N**
Are You Using Birth Control? **Y** **N** Type:	**Pap Test** _____ Normal or Abnormal	**Health Proxy**	**Y**	**N**
Number of Pregnancies? _____ Number of Births? _____	**Breast Exam** _____ Normal or Abnormal	**Is Your Home Safe**	**Y**	**N**
Number of Abortions? _____	**Mammogram** _____ Normal or Abnormal	**Bike Helmets**	**Y**	**N**
Number of Miscarriages? _____		**Exercise**	**Y**	**N**

Comments:

Reviewed by: Print Name: **Signature:** **Date:**