Khair Family Practice, PC

Name:_____ Date: _____

DOB: _____

Chief Complaint(reason for visit):

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

_____

Current Meds:

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Consulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	*Date*	*Reason*	*Date*

Medical History: place an x in the boxes that apply

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart palpatations
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Dizziness/Fainting
- ☐ Peripheral vascular disease
- ☐ Allergies/Hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI disorder
- ☐ Lactose intolerant
- ☐ Gallbladder disease
- ☐ Prostate disease
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Sexual/Menstrual dysfunction
- ☐ Veneral disease
- ☐ Frequent infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet Fever
- ☐ Chronic rashes
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diptheria
- ☐ Tetanus
- ☐ Other _____
- ☐ Other _____

Habits:

- ☐ Smoke: Packs daily: _____
  How Long: _____
  Interested in stopping? ____
- ☐ Exercise:_____
  How often: _____
- ☐ Contact with blood/bodily fluid at work
- ☐ Coffee: cups daily _____
  other caffeine _____
- ☐ Alcohol: type _____
  Amount _____
- ☐ Diet: Salt intake _____
  Fat intake _____

Sleep :

- ☐ Difficulty falling asleep
- ☐ Continuity disturbances
- ☐ Snoring
- ☐ Early morning awakening
- ☐ Daytime drowsiness
- ☐ Other _____