**FLOWER MOUND FAMILY PHYSICIANS**

Date:\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Please Circle: Male Female

Ethnicity (Please Circle): Asian African American Caucasian Hispanic

**Medical Conditions and Date of Onset (Check all that apply):**

Asthma\_\_\_\_\_\_\_\_\_\_ Hepatitis\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_ High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_ Liver Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease\_\_\_\_\_\_\_\_\_ Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any conditions not listed above and the date of onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List all surgeries Date Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_**

**Immunizations and date of immunization:**

□Tetanus\_\_\_\_\_\_\_ □Hepatitis A\_\_\_\_\_\_\_\_\_\_ □Hepatitis B\_\_\_\_\_\_\_\_\_

□Zostavax(Shingles)\_\_\_\_\_\_\_\_\_ □Prevnar 13\_\_\_\_\_\_\_\_\_\_ □Pneumovax\_\_\_\_\_\_\_\_\_

□Influenza\_\_\_\_\_\_\_\_ □COVID-19\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any medications? Yes\_\_ No\_\_ (**If yes please list the medication and the reaction)

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**List of current medications including any OTC medication(Tylenol, Aspirin, Vitamins etc):**

**Name of medication Dose Directions**

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**Family History:**

Father: Living, age:\_\_\_ Deceased, age at death:\_\_\_ Cause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living, age:\_\_\_ Deceased, age at death:\_\_\_ Cause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: Number Living:\_\_ Number Deceased:\_\_\_ Cause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

Cancer\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TB\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products? Yes/No If yes please circle: Cigarettes Cigars, E-Cig

Chewing Tobacco

If Yes, how much per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a former smoker, when did you quit? \_\_\_\_\_\_\_\_\_\_\_

Alcohol use? Yes/No If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems:** Please check all symptoms that apply

**Allergies:** **Cardiovascular:**

Seasonal Allergies\_\_ Chest Pain\_\_

Hay Fever\_\_ Passing Out\_\_

**Constitutional:** Swelling\_\_

Appetite Change\_\_ **Ears, Nose, Throat:**

Chills\_\_ Change in Hearing\_\_

Fatigue\_\_ Nose Bleeds\_\_

Fever\_\_ Ringing in Ears\_\_

Weight Change\_\_ **GYN:**

**Gastrointestinal** Breast Mass/Discharge\_\_

Abdominal Pain\_\_ **Hematology:**

Bloody Stool\_\_ Anemia\_\_

Bowel Changes\_\_ Bleeding\_\_

Constipation\_\_ Bruise Easily\_\_

Diarrhea\_\_ Swollen Glands\_\_

Heartburn/Indigestion\_\_

**Musculoskeletal:** **Neurological:**

Back Pain\_\_ Epilepsy\_\_

Bursitis\_\_ Numbness/Tingling\_\_

Gout\_\_ Paralysis\_\_

Joint Pain/Stiffness\_\_ Stroke\_\_

Osteoporosis\_\_ Trouble with Speech\_\_

**Ophthalmology:** **Psychological:**

Dizziness\_\_ Anxious\_\_

Headaches\_\_ Depressed\_\_

Vision Changes\_\_ Stress\_\_

**Respiratory:** **Skin:**

Cough\_\_ Hives\_\_

Shortness of Breath\_\_ Itching\_\_

Wheezing\_\_ Rash\_\_

**Urinary:** Skin Cancer\_\_

Blood in Urine\_\_

Burning with Urination\_\_