HAMPTON FAMILY PRACTICE
Treating You Like Family

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Past Medical History Form

Today's Date: _____ Other ID # _____

Name:		Date of Birth:
Age:	Circle: Male Female	Present Occupation:
Circle your current marital status:	Single Divorced Married Other	
Do you have a designee to make medical decisions on your behalf?		If yes, provide name:
Pregnancies (*Females only*): Number: _____		

If your appointment is scheduled for a physical or wellness exam, provide any additional conditions or concerns that you would like to address with your provider today.	
1)	4)
2)	5)

Preferred Pharmacy:		
List Current Medications or circle: NONE	**Dose**	**Frequency**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

List Allergies or circle: NONE			
Allergy	**Reaction**	**Allergy**	**Reaction**
1)		4)	
2)		5)	
3)		6)	

Social History	
Do you currently smoke? Yes No	If so, how many cigarettes per day? If so, what age did you start?
Have you previously smoked? Yes No	If so, when did you quit and how much did you smoke?
Do you drink alcohol? Yes No	If so, how many drinks per week?
How would you rate your level of physical activity? None Light Moderate Intense	

Medical Conditions: Circle the appropriate boxes.				
Asthma	Depression	Gout	Migraines	Other:
ADD/ADHD	Diabetes	Heart disease	Neurological problems	
Arthritis	Diverticulosis	High blood pressure	Reflux/Ulcers	
Blood clotting disorder	Emphysema	High cholesterol	Stroke	
Cancer, type:	Genetic disease	Liver disease	Thyroid disease	

Name:	Date of Birth:

List Major Surgeries and Hospitalizations or circle: NONE		
Year	**Operation or illness**	**Location**
1)		
2)		
3)		
4)		
5)		

List any specialists or other healthcare providers involved in your care.	
Specialty	**Healthcare Provider**
1)	
2)	
3)	
4)	
5)	

Family History: Check the appropriate boxes.						**Use empty rows to add additional family members.**		
Family Relation	**Living:**	**Hypertension**	**Diabetes**	**High cholesterol**	**Stroke**	**Heart disease**	**Cancer, type:**	**Other:**
Birth Mother	Y or N							
Birth Father	Y or N							
Birth Sister	Y or N							
Birth Brother	Y or N							
	Y or N							
	Y or N							
	Y or N							
	Y or N							

Additional Medical Information: We understand some of the information requested on this form may already be in your health record; however, it is helpful for you to provide the information requested on this form for review and accuracy. Please enter the year for the below listed procedures.

Colonoscopy:	Mammogram:	Shingles Shot:
EGD/Endoscopy:	Pap Smear:	Pneumonia Shot:
Tetanus Shot:	Bone Density Scan/DEXA:	Flu Shot:

Additional lines if needed:

Name of person completing this form: _____ Relation: _____

Patient Signature or POA: _____ Date: _____

Reviewed and entered by HFP staff: _____ *Date:* _____