KACHINA FAMILY PRACTICE ADULT MEDICAL HISTORY

First Name: ____ **Last:** ____ **DOB:** ____ **AGE:** ____ **EMAIL:** ____

Pharmacy Name: ____ **Pharmacy Cross Streets:** ____ **Pharmacy Phone #** ____

CURRENT MEDICATIONS

1. ____ Dose: ____ Times/day: ____
2. ____ Dose: ____ Times/day: ____
3. ____ Dose: ____ Times/day: ____
4. ____ Dose: ____ Times/day: ____
5. ____ Dose: ____ Times/day: ____
6. ____ Dose: ____ Times/day: ____

ALLERGIES TO MEDICATIONS: ○ None ○ Yes (if Yes, list below)

Medication ____ Type of Reaction ____ Medication ____ Type of Reaction ____

PAST MEDICAL HISTORY

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes: ○ Type I ○ Type II
- ☐ Erectile Disfunction
- ☐ GERD/Acid Reflux
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Other: ____

SURGERIES

____ Year ____ ____ Year ____
____ Year ____ ____ Year ____

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ Partnered **Children:** Girls ____ Boys ____ **Occupation** ____

Who do you live with? ____ Pets? ____
Years in Arizona? ____ State(s) before Arizona? ____ Hobbies? ____

Are you Sexually active ? ○ Yes ○ No Sexual Orientation: do you prefer ○ Men ○ Women ○ Both

Tobacco ○ Yes ○ No ○ Former , Years used ____, **Type:** ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
Amount (packs/day): ○ 2 ○ 1½ ○ 1 ○ 3/4 ○ 1/2 ○ 1/3 ○ less than ¼ ○ Occasional

Alcohol ○ Yes ○ No ○ Former Amount: ____ Drinks per ○ day ○ week ○ month ○ year

Diet Habits: ○ Excellent ○ Good ○ Average ○ Needs Improvement ○ Poor ○ Lots of Fast Food
Exercise: ☐ None Type of Exercise ____ Frequency: ____ minutes, ____ times per week.

FAMILY MEDICAL HISTORY

MOTHER

○ Alive ○ Deceased

Age, or age at death ____

Cause of death ____

MEDICAL PROBLEMS:

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer, Type ____
- ☐ Depression
- ☐ Diabetes: ○ Type I ○ Type II
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Obesity
- ☐ Osteoporosis

FATHER

○ Alive ○ Deceased

Age, or age at death ____

Cause of death ____

MEDICAL PROBLEMS:

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer, Type ____
- ☐ Depression
- ☐ Diabetes: ○ Type I ○ Type II
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Obesity
- ☐ Osteoporosis

SIBLINGS

Number of Brothers ____ Sisters ____

Cause(s) of death ____

MEDICAL PROBLEMS:

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer, Type ____
- ☐ Depression
- ☐ Diabetes: ○ Type I ○ Type II
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Obesity
- ☐ Osteoporosis

PREVENTIVE CARE (When did you last have the following?)

Physical ____ Colonoscopy ____ Mammogram ____ Tetanus Vaccine ____ Pneumonia Vaccine ____ Flu Vaccine ____ Bone Density Scan ____

OB/GYN HISTORY

Pregnancies ____ Live Births ____ Miscarriages ____ Abortions ____ Last PAP Smear: Date ____ Through: ○ PCP or ○ Gynecologist

How did you hear about Kachina Family Practice? ____