MORRIS SUSSEX FAMILY PRACTICE

HISTORY SHEET

DATE: _____

Name: _____ Phone: _____ DOB: _____

YOUR MEDICAL HISTORY (CHECK WHERE APPLICABLE):

☐ Hypertension	☐ Bleeding Disorders	☐ Mental Illness
☐ Diabetes	☐ Asthma	☐ Musculoskeletal Disease
☐ High Cholesterol	☐ Neurological Disease	☐ Mononucleosis
☐ Seizures (Epilepsy)	☐ Phlebitis	☐ Vaginal Infections
☐ Stroke	☐ Hepatitis	☐ Ear Diseases
☐ Sinusitis	☐ Arthritis	☐ Pneumonia
☐ Heart Disease	☐ Rheumatic Fever	☐ Urinary Tract Infection
☐ Lung Disease	☐ Scarlet Fever	☐ Glaucoma
☐ Kidney Stones	☐ Thyroid Disease	☐ Cataracts
☐ Stomach Ulcers	☐ Gallstones	☐ Chicken Pox
☐ Diverticulitis	☐ Cancer	☐ Measles
☐ Kidney Disease	☐ Pancreatitis	☐ Liver Disease

YOUR SURGICAL HISTORY (LIST ALL OPERATIONS & DATES): _____

MEDICATIONS: _____

ALLERGIES TO MEDICATION/FOOD ☐ YES ☐ NO If yes, please list: _____

Last Mammogram (Date and Facility): _____

Last Cervical Cancer Screening (Date and Provider): _____

Last Colonoscopy (Date and Provider): _____

Last Diabetic Eye Exam (Date and Provider): _____

Have you ever smoked? ☐ YES ☐ NO

Do you smoke now? ☐ YES ☐ NO

How many per day/week? _____

Do you drink alcohol? ☐ YES ☐ NO

How many per day/week? _____

Have you served in the military? ☐ YES ☐ NO

Have you ever lived in another country? ☐ YES ☐ NO

Where? _____ How long ago? _____

Do you now use any recreational drugs? ☐ YES ☐ NO

How many caffeinated beverages do you drink per day? _____ Occupation: _____

FAMILY HISTORY - Name Any Blood Relative(s) or Siblings, Parents, or Grandparents:

Colon Cancer	☐ YES ☐ NO	Prostate Cancer	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Lung Cancer	☐ YES ☐ NO	Penile Cancer	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Breast Cancer	☐ YES ☐ NO	Testicular Cancer	☐ YES ☐ NO	Alcohol/Drug Abuse	☐ YES ☐ NO
Ovarian Cancer	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Mental Illness	☐ YES ☐ NO
Cervical Cancer	☐ YES ☐ NO	Heart Attack	☐ YES ☐ NO	Neurological Disease	☐ YES ☐ NO
Uterine Cancer	☐ YES ☐ NO	Gastrointestinal Disease	☐ YES ☐ NO	Stroke	☐ YES ☐ NO