# Flagler Family Medicine, P.A.

**Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:**

| CONDITION | YOU | LIST - RELATIVE | CONDITION | YOU | LIST - RELATIVE |
|---|---|---|---|---|---|
| DIABETES | | | ANEMIA | | |
| HIGH BLOOD PRESSURE | | | LEUKEMIA | | |
| STROKE | | | SICKLE CELL | | |
| HEART ATTACK | | | BLEEDING PROBLEMS | | |
| ASTHMA | | | STOMACH ULCER | | |
| MIGRAINE HEADACHES | | | GALLSTONES | | |
| CANCER | | | SEIZURES | | |
| EMPHYSEMA | | | TUBERCULOSIS | | |
| KIDNEY PROBLEMS | | | ALCOHOLISM | | |
| ARTHRITIS | | | SUICIDE | | |
| GLAUCOMA / EYE PROBLEMS | | | DEPRESSION | | |
| SKIN RASH | | | MENTAL ILLNESS | | |
| OTHER | | | OTHER | | |

**OPERATIONS / SURGERIES**: _____

_____

_____

**Last Colonoscopy:**_____

**OTHER HOSPITALIZATIONS:** _____

_____

**BLOOD TRANSFUSIONS:** _____

**MEDICATIONS:** _____ _____ _____

_____ _____ _____

_____ _____ _____

**Last Pneumonia Vaccine(Pneumovax or Prevnar):**_____

**Last Flu Vaccine:**_____

**ALLERGIES:** (Any reaction to any medication of any kind?) _____

**OCCUPATION / WORK HISTORY:** _____

**Any exposure to pesticides, chemicals, or other hazards?** YES _____ NO _____

**If yes, What kind?** _____

**Family / Household:** (Who lives at home with you?)_____

_____

_____

**HABITS:** Cigarettes: _____ PPD ____ X _____ years Quit in _____ (year)

Other Tobacco Products? _____ Alcohol _____

Drug Use _____ Caffeine (coffee/colas)_____

Seat Belt Use: Yes: _____ No _____ Exercise: _____

Age of first menstrual period _____ How many days between periods? _____

How many days does it last? _____ Is bleeding heavy or light? _____

Date of last menstrual period _____ Was it normal? _____

If menstrual periods have stopped, have you had any bleeding since? _____

Any Vaginal Discharge? Yes _____ No _____

Method of Preventing Pregnancy _____

Pregnancies _____ Births _____ Abortions/Miscarriages _____

Last Mammogram:_____Last Bone Density:_____

Last Pap Smear: _____

Any other concerns? _____

_____

_____

**Name:** _____

**Social Security:** _____

**Birth Date:** _____