Midnight Sun Family Medicine, P.C.
Patient Health Survey

NAME _____DATE OF BIRTH ___/___/___DATE _____

PAST MEDICAL HISTORY

Have you ever had any surgery? ○ **No** ○ **Yes**

List: ☐ Appendectomy ☐ Hysterectomy (If so, reason _____)
☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what _____)
☐ Other (please list) _____

Have you ever had any of the following?

☐ Asthma ☐ High Blood Pressure ☐ Cancer (site _____) ☐ Diabetes
☐ Ulcer or Gastritis ☐ Thyroid Problems ☐ Tuberculosis ☐ Kidney Problems
☐ Liver Problems ☐ Blood Problems ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Abnormal Heart Rhythm ☐ Fractures (site _____)

Have you had any other serious illness? ○ No ○ Yes
Have you ever had a transfusion? ○ No ○ Yes
Have you ever been hospitalized or been under medical care for very long? ○ No ○ Yes
If yes to any of the above questions, for what reason? _____
Have you had an eye exam within the last year? ○ No ○ Yes
Are you current on your immunizations? ○ No ○ Yes ○ Unsure

Medications: _____
Allergies: _____
Pharmacy:_____

For Females Only:

Pregnancies:_____ Live Births: ____ Miscarriages: ____ Abortions: ____
Date of Last Pap Smear: _____ Results: ○ Normal ○ Abnormal
Date of Last Mammogram: _____ Results: ○ Normal ○ Abnormal
Date of Last Menstrual Period: _____ Age when menses started: _____
Describe Menstrual Flow: ☐ Regular ☐ Irregular Flow Amount: ○ Light ○ Moderate ○ Heavy
☐ Painful ☐ Cramps ☐ Headaches ☐ Other _____
How many days does your menses last? _____ How many days between your menses? _____
What is your method of birth control? _____

SOCIAL HISTORY

Circle One: Single Married Divorced Separated Widowed Significant Other
With whom do you live? _____

Occupation: _____ Are you exposed to fumes, dusts, or solvents? _____
Do you have any pets? ○ No ○ Yes If yes, what type? _____
Do you eat a balanced diet? ○ No ○ Yes Do you exercise routinely? ○ No ○ Yes
Do you use tobacco? ☐ Never Years smoked _____ How much? _____ Quit _____years ago
Do you consume alcohol? ☐ Never ☐ <1 per week ☐ 1-5 per week Other _____
Do you use recreational drugs? ○ No ○ Yes If yes, what type?_____
Do you have a Living Will? ○ No ○ Yes Are you an organ donor? ○ No ○ Yes
(Females only) Do you perform breast exams? ○ No ○ Yes
(Males only) Do you perform testicular exams? ○ No ○ Yes
Are there guns in your home? ○ No ○ Yes Are they secured/locked? ○ No ○ Yes
Do you use seatbelts? ○ No ○ Yes Do you have a functioning smoke detector in your home? ○ No ○ Yes

FAMILY HISTORY

Father: Alive (Age ____) Deceased (Age____) Medical problems_____
Mother: Alive (Age ____) Deceased (Age____) Medical problems_____
Paternal Grandmother: Alive (Age ____) Deceased (Age____) Medical problems_____
Paternal Grandfather: Alive (Age ____) Deceased (Age____) Medical problems_____
Maternal Grandmother: Alive (Age ____) Deceased (Age____) Medical problems_____
Maternal Grandfather: Alive (Age ____) Deceased (Age____) Medical problems_____
Brothers____ Sisters____ Medical Problems: _____

Children_____ Children's Current/Past Health Status: _____

Have any of your blood relatives had any of the following (circle all that apply)?
☐ Heart Trouble ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ Cancer (site_____)