GILMAN FAMILY PRACTICE Today's Date_____

Patient Name: _____ Date of Birth: _____

Previous Family Physician: _____ Last Visit/Physical:_____

Past Medical History **Please Circle the following you have or had** **Please Specify**

Diabetes/Thyroid/Endocrine Problems _____

Heart/Vascular Problems _____

Lung Problems/Asthma/COPD _____

Kidney or Urinary Problems _____

Liver Problems or Viral Hepatitis _____

Bleeding or Clotting Problems _____

Cancer or any Tumors _____

Neurological/Brain Problems/ Headaches _____

Depression/Anxiety/Psychiatric _____

Osteoarthritis or joint problems _____

Autoimmune/Rheumatoid Arthritis/Lupus _____

Hearing or Vertigo Disorders _____

Gastroenterology Disorders _____

Speech or Swallowing Disorders _____

Sinus/Nasal/Eye/Facial Problems _____

Skin Disorders _____

Sleep Disorders/Apnea/CPAP _____

Date of Last Mammogram: _____ Where was it done? _____

Colon Screening: _____Colonoscopy ____Cologuard ____FOBT
Date it was done: _____ Where: _____

Family History

Circle which of the following run-in your family. Please Specify:

Cancer or Benign Tumors _____

Diabetes, Thyroid, Osteoporosis _____

Neurological (i.e. Migraines, Strokes, MS) _____

Heart (i.e. Heart failure/attack, murmurs, blood pressure) _____

Lung (i.e. COPD, Asthma) _____

Autoimmune Disorders (i.e. Lupus, Arthritis) _____

Depression (i.e. bipolar, alcoholism) _____

Social History

Occupation/what do you do for a living? _____

Please circle the appropriate answer:

Exercise: Yes No If yes. Frequency and what type: _____

Marital Status: Single Divorced Married Separated Significant Other Widowed

Caffeine Use: Never Daily Occasional **Alcohol Consumption**: Daily 1-4 Times/Week Less than 1 time/week Never

Smoking: Never Yes. How often? _____ Yes, but I quit. When? _____

Vaping (nicotine): Never Yes. How often? _____ Yes, but I quit. When? _____

Chew Tobacco: Never Yes. How often? _____ Yes, but I quit. When? _____

Recreational Drugs: Never Marijuana. Cocaine. Heroin or Opioids. Other: _____

Do you have any allergies to medications? No Yes. If yes, please list the medication and reaction below:

_____

_____

Past Surgical History:

Surgery/Year	Surgery/Year	Surgery/Year	Surgery/Year
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.	15.	16.