Andover Family Medicine
PMH/Family-Social History/ROS
(Please FILL in the Bubbles)

Name: _____
DOB: _____

Past Medical History

Acid Reflux	O Yes	Alcohol Abuse	O Yes	Allergic Rhinitis	O Yes
Anemia	O Yes	Anxiety	O Yes	Arthritis	O Yes
Asthma	O Yes	Atrial Fibrillation	O Yes	Bipolar	O Yes
BPH	O Yes	Cancer	O Yes	CHF	O Yes
Depression	O Yes	Diabetes	O Yes	Dementia	O Yes
Glaucoma	O Yes	Hay Fever	O Yes	Heart Disease	O Yes
Hepatitis C	O Yes	High Blood Pressure	O Yes	High Cholesterol	O Yes
Irritable Bowel Synd	O Yes	Kidney Disease	O Yes	Liver Disease	O Yes
Migraine Headache	O Yes	Mitral Valve Prolapse	O Yes	Pacemaker	O Yes
Rheumatic Fever	O Yes	Seizures	O Yes	Sinus Disease	O Yes
Sleep Apnea	O Yes	STD History	O Yes	Stroke	O Yes
Thyroid Disease	O Yes	Tuberculosis	O Yes	Vertigo	O Yes

Other (please list): _____

Surgical History

Appendectomy	O Yes	Back Surgery	O Yes
C-Section	O Yes	Cardiac Catheterization	O Yes
Coronary Artery Bypass Graft	O Yes	Gall Bladder	O Yes
Hysterectomy	O Yes	Knee Replacement	O Yes
Lithotripsy	O Yes	Pacemaker, Cardiac	O Yes
Thyroidectomy	O Yes	Tonsillectomy	O Yes
Tubal ligation	O Yes	Vasectomy	O Yes

Other (please list): _____

Current Medications:

Name of Drug:	Strength of Drug:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Please list all medications including over the counter and herbal supplements

Drug Allergies/intolerances: O Yes O No

If **Yes**, Please list name of drugs and symptoms of allergy (for example: rash/nausea/vomiting):

_____

_____

Name of Pharmacy: _____ **Location:** _____

Do you prefer 30 or 90 days for maintenance prescriptions? _____

Do you use mail order pharmacy? O Yes O No Location: _____

Andover Family Medicine
PMH/Family-Social History/ROS
(Please FILL in the Bubbles)

Family History

Does your mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your paternal grand mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your paternal grand father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your maternal grand mother have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Does your maternal grand father have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Do any of your siblings have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Do any of your children have any of the following?
O Diabetes O High Blood Pressure O Heart Disease O Stroke O Mental Illness O Cancer

Social History

Number of: Brothers_____ Sisters_____ Sons_____ Daughters_____

Do you smoke? O Yes O No
If **yes**, how many packs per day? _____
If **no**, have you smoked in the past? _____
Are you exposed to smoke? O Yes O No
Do you drink caffeine? O Yes O No
Do you drink alcohol? O Yes O No
Illegal drug use history? O Yes O No
Do you exercise? O Yes O No
Are you sexually active? O Yes O No
Smoke detector in home? O Yes O No
Do you have pets? O Yes O No
Marital Status: O Single O Married O Significant Other O Divorced O Widowed
Occupation: _____

Immunization/Preventive Health (Please list month/year if known)

Date of last eye exam: ____/_____
Date of last dental exam: ____/_____
Date of last chest x-ray: ____/_____
Date of last Colonoscopy: ___/_____
(**M**)Date of last prostate exam: ___/_____
(**W**)Date of last mammogram: ___/_____
(**W**)Date of last pap smear: ___/_____
Date of last bone density/DEXA: ___/_____
(**W**)Have you had an abnormal pap smear? O Yes O No
Have you had the HPV/cervical cancer vaccine? O Yes O No
Have you had the shingles vaccine/Zostavax ? O Yes O No
Have you had a pneumonia vaccine? O Yes O No
When was you last tetanus immunization: Year: _____

Please list below any other concerns or items not addressed above: