Lafayette Family Care

ADULT MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Patient Name: _____ Today's Date: _____Date of Birth: _____

Are you allergic to any medication? □No □Yes, please specify: _____

Reaction: _____

Are you allergic to any kind of food and/or bee stings? □No □Yes, please specify: _____

Marital Status: □ Single □ Married □ Divorced □Separated □Widow □Other

Race: □ American Indian/Alaska Native □ Asian □ Native Hawaiian or other Pacific Island

□ Black/African American □ White/Caucasian □Other (please specify): _____

Preferred Language: □English □Spanish □French □Other (please specify): _____

Do You Need: □ An Interpreter □ Sign Language □ Not Applicable

Education Level: □ High School □ College-Graduate □ Post-Graduate

Ethnicity: _____Religion: _____ Occupation _____

MEDICATION:

CURRENT MEDICATIONS □ No □Yes:

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

PREVIOUS MEDICATIONS：***Last 5 years***

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS VITAMINS/MINERALS/HERBS/HOMEOPATHY):

SUPPLMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems?

○ Yes ○ No Describe: _____

Please check box below if yes and provide date of onset:

RESPIRATORY DISEASES

☐ Asthma_____
☐ Bronchitis _____
☐ Emphysema _____
☐ Chronic Sinusitis _____
☐ Sleep Apnea _____
☐ Pneumonia _____
☐ Tuberculosis _____
☐ Other _____

CARDIOVASCULAR

☐ Hypertension (high blood pressure) _____
☐ Elevated Cholesterol _____
☐ Heart Attack _____
☐ Stroke _____
☐ Arrhythmia (irregular heart rate) _____
☐ Other Heart Disease _____
☐ Mitral Valve Prolapse _____
☐ Rheumatic Fever _____
☐ Other _____

NEUROLOGIC/MOOD

☐ Depression _____
☐ Anxiety _____
☐ Bipolar Disorder _____
☐ ADD/ADHD _____
☐ Schizophrenia _____
☐ Autism _____
☐ Mild Cognitive Impairment _____
☐ Headaches _____
☐ Migraines _____
☐ Memory Problems _____
☐ Parkinson's Disease _____
☐ Multiple Sclerosis _____
☐ ALS _____
☐ Seizures _____
☐ Other Neurological Problems _____

GASTROINTESTINAL

□ GERD (reflux) _____
□ Gastritis or Peptic Ulcer Disease _____
□ Ulcerative Colitis_____
□ Irritable Bowel Syndrome _____
□ Inflammatory Bowel Disease _____
□ Crohn's _____
□ Celiac Disease _____
□ Other _____

METABOLIC/ENDOCRINE

□ Type 1 Diabetes _____
□ Type 2 Diabetes _____
□ Hypoglycemia _____
□ Metabolic Syndrome _____
□ (Insulin Resistance or Pre-Diabetes) _____
□ Hypothyroidism (low thyroid) _____
□ Hyperthyroidism (overactive thyroid) _____
□ Polycystic Ovarian Syndrome (PCOS) _____
□ Infertility _____
☐ Weight Gain _____
☐ Weight Loss _____
☐ Frequent Weight Fluctuations _____
☐ Bulimia _____
☐ Anorexia _____
☐ Binge Eating Disorder _____
☐ Night Eating Syndrome _____
☐ Eating Disorder (non-specific_____
☐ Other _____

GENITAL AND URINARY SYSTEMS

☐ Frequent Urinary Tract Infections _____
☐ Frequent Yeast Infections _____
☐ Kidney Stones _____
☐ Interstitial Cystitis _____
☐ Gout _____
☐ Erectile Dysfunction or Sexual Dysfunction __
☐ Other _____

MUSCULOSKELETAL/PAIN

☐ Osteoarthritis _____
☐ Fibromyalgia _____
☐ Chronic Pain _____
☐ Other _____

SKIN DISEASES

☐ Eczema _____
☐ Psoriasis _____
☐ Acne _____
☐ Melanoma _____
☐ Skin Cancer _____
☐ Other _____

INFLAMMATORY/AUTOIMMUNE

☐ Chronic Fatigue Syndrome _____
☐ Autoimmune Disease _____
☐ Rheumatoid Arthritis _____
☐ Lupus SLE _____
☐ Immune Deficiency Disease _____
☐ Herpes-Genital _____
☐ Severe Infectious Disease _____
☐ Poor Immune Function _____
☐ Frequent infections _____
☐ Food Allergies _____
☐ Environmental Allergies _____
☐ Multiple Chemical Sensitivities _____
☐ Latex Allergy _____
☐ Other _____

CANCER

☐ Lung Cancer _____
☐ Breast Cancer _____
☐ Colon Cancer _____
☐ Ovarian Cancer _____
☐ Prostate Cancer _____
☐ Skin Cancer _____

INJURIES

Check box if yes: □Back Injury □Head Injury □Neck Injury □Broken Bones

SURGERIES

Check box if yes and provide date of surgery

☐ Appendectomy _____
☐ Hysterectomy + / - Ovaries _____
☐ Gall Bladder _____
☐ Hernia _____
☐ Tonsillectomy _____
☐ Dental Surgery _____
☐ Joint Replacement – Knee/Hip _____
☐ Heart Surgery-Bypass Valve _____
☐ Angioplasty or Stent _____
☐ Pacemaker _____
☐ Other _____
☐ None _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

☐ Full Physical Exam _____
☐ Bone Density _____
☐ Colonoscopy _____
☐ Cardiac Stress Test _____
☐ EBT Heart Scan _____
☐ EKG _____
☐ Hemoccult Test-stool test for blood _____
☐ MRI _____
☐ CT Scan _____
☐ Upper Endoscopy _____
☐ Upper GI Series _____
☐ Ultrasound _____