

STECK MEDICAL GROUP

PAST, FAMILY, AND SOCIAL HISTORY

Patient Name: _____ Age: _____ Date: _____

MEDICINES TAKEN REGULARLY	Reason

PERSONAL PAST HISTORY			
Have you ever had?	Year	Operations	Year
Measles	yes no	Tonsil	yes no
Mumps	yes no	Appendix	yes no
Whooping cough	yes no	Gallbladder	yes no
Polio	yes no	Stomach	yes no
Diphtheria	yes no	Breast	yes no
Meningitis	yes no	Uterus, ovary	yes no
Valley fever	yes no	Prostate	yes no
Malaria	yes no	Hernia	yes no
Hives	yes no	Thyroid	yes no
Cancer	yes no	Varicose veins	yes no
Venereal Disease	yes no	Hemorrhoids	yes no
Arthritis	yes no	Hip	yes no
Rheum. Fever	yes no	Knee	yes no
Heart Failure	yes no	Other:	_____
Blood transfusions	yes no		
Hepatitis	yes no		
Kidney disease	yes no		
Hay fever	yes no		
Glaucoma	yes no		
Thyroid Disease	yes no		
Other:			

INJURIES		Year
Head	yes no	
Chest	yes no	
Abdomen	yes no	
Broken bones	yes no	
Back	yes no	
Other:		

IMMUNIZATIONS		Year
Influenza	yes no	
Pneumococcal	yes no	
Tetanus	yes no	
Hepatitis B	yes no	

OB/GYN		Year
Pregnancies	#	
Miscarriages	#	
Abortions	#	
First Period:		
Last Period:		

ALLERGIES		Year
Tetanus	yes no	
Penicillin	yes no	
Sulfa	yes no	
Other		

SOCIAL HISTORY #1	
Birth Place:	Birth Date:
Religion:	Marital Status:
Occupations:	
Do you have a "Living Will?"	yes no

PRACTITIONER'S NOTES

FAMILY HISTORY		
Have you or any blood relative had any of the following:		
		Relationship
Anemia	yes no	_____
Bleeding tendency	yes no	_____
Repeated infections	yes no	_____
Heart Attack/Angina	yes no	_____
Chronic lung disease	yes no	_____
Tuberculosis	yes no	_____
High Blood Pressure	yes no	_____
Asthma	yes no	_____
Severe allergies	yes no	_____
Mental or emotional illness	yes no	_____
Seizures	yes no	_____
Migraine headaches	yes no	_____
Diabetes	yes no	_____
Gout	yes no	_____
Obesity	yes no	_____
Ulcer	yes no	_____
Chronic diarrhea	yes no	_____
Cancer/Leukemia	yes no	_____
Alcohol or Drug Problem	yes no	_____
Family violence/abuse	yes no	_____

Present age or age at death	If living, health good, fair or poor. If deceased, cause of death.
Father	
Mother	
Brothers or Sisters	
Spouse	
Children	

SOCIAL HISTORY #2	
In an average week I exercise or work vigorously:	hrs
My compliance with a healthy diet:	poor fair good excellent
My religious faith is:	none average important vital
My sexual orientation is:	heterosexual homosexual ("gay") other

AVERAGE PER DAY	
Alcohol – type	_____
Tobacco – type	_____
Tea or coffee	_____

Please complete both sides

**CURRENTLY or in the last six months have you experienced:
(Circle 'yes' or 'no' – if in doubt, leave blank)**

GENERAL:		
Fatigue, tiring easily	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
EYES:		
Trouble seeing	yes	no
Eye pain	yes	no
Inflamed eyes	yes	no
Wear glasses	yes	no
EARS, NOSE & THROAT:		
Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge from an ear	yes	no
Loss of smell	yes	no
Nasal obstruction	yes	no
Excess nasal discharge	yes	no
Nose bleeds	yes	no
Sore gums or tongue	yes	no
Dental problems	yes	no
Post nasal drainage	yes	no
Hoarseness	yes	no
NECK:		
Stiffness, swelling, or pain	yes	no
CARDIAC SYSTEM:		
Chest pain	yes	no
Swelling of ankles	yes	no
Bluish fingers or lips	yes	no
High blood pressure	yes	no
Palpitations	yes	no
Vein trouble	yes	no
RESPIRATORY SYSTEM:		
Shortness of breath	yes	no
Cough, persisting	yes	no
Bloody sputum	yes	no
Wheezing	yes	no
DIGESTIVE SYSTEM:		
Change in appetite	yes	no
Difficulty swallowing	yes	no
Heartburn	yes	no
Abdominal pain	yes	no
Abdominal enlargement	yes	no
Belching or excess gas	yes	no
Nausea or vomiting	yes	no
Vomiting of blood	yes	no
Rectal bleeding	yes	no
Dark stools	yes	no
Constipation	yes	no
Diarrhea	yes	no
Hemorrhoids	yes	no
Any food intolerance	yes	no
Need for laxatives	yes	no
Which?	_____	

GENITOURINARY SYSTEM:		
Unable to hold urine	yes	no
Pain or burning on urination	yes	no
Nighttime urination	yes	no
Blood in urine	yes	no
Satisfied with sexual activity	yes	no
Vaginal discharge or malodor	yes	no
Pain with intercourse	yes	no
LOCOMOTOR:		
Muscle cramps	yes	no
Muscle weakness	yes	no
Joint pain, swelling, or stiffness	yes	no
SKIN:		
Rash	yes	no
Hives or itching	yes	no
Change in hair or nails	yes	no
Dry skin	yes	no
Easy bruising	yes	no
Change in a mole	yes	no
Non healing sore	yes	no
BREASTS/CHEST:		
Lumps	yes	no
Pain	yes	no
Discharge	yes	no
NERVOUS/MENTAL SYSTEM:		
Headaches	yes	no
Dizziness/loss of balance	yes	no
Fainting	yes	no
Seizures or epilepsy	yes	no
Memory loss	yes	no
Change in sensation	yes	no
Poor coordination	yes	no
Weakness or paralysis	yes	no
Nervousness, anxiety	yes	no
Sleeplessness	yes	no
Depression, grief, or sadness	yes	no
Family problems	yes	no
Occupational concerns	yes	no
Hard to find pleasure	yes	no
ENDOCRINE:		
Excess thirst	yes	no
Menstrual problems	yes	no
Intolerance to heat or cold	yes	no
Hot flashes	yes	no
HEMATOLOGIC & IMMUNOLOGIC:		
Lymph node swelling or pain	yes	no
Allergy symptoms	yes	no
Risk of HIV (AIDS)	yes	no
Any other current concerns:		

Please complete **both** sides