ENSIGN Family Medicine, LLC

5771 South Fort Apache Rd. Ste # 100
Las Vegas, NV 89148
Phone: (702) 951-3400
Fax (702) 951-3403

PATIENT HEALTH HISTORY

** This questionnaire will become a confidential part of your medical record and will help us serve your healthcare needs more effectively and efficiently. Please fill out this form completely.*

PATIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH
REASON FOR VISIT:	

1. ALLERGIES (to medications): **Yes** **No**

If yes, please list any known allergies:

1.______________________________ 2.____________________________ 3.__________________________ 4.__________________________

2. CURRENT MEDICATIONS

Prescriptions or over the counter (including vitamins and herbs):

1.____ 4.____

2.____ 5.____

3.____ 6.____

3. MEDICAL HISTORY (check all that apply)

ILLNESS	YES	NO	ILLNESS	YES	NO
Anemia/Blood Transfusions			Heart Murmur		
Anxiety			Hemorrhoids		
Arthritis			Hepatitis/Jaundice		
Asthma			High Blood Pressure		
Bleeding Tendencies			HIV/AIDS		
Cancer/Tumors			Kidney or bladder problems		
Cataracts			Kidney Stones		
Depression			Liver Disease		
Diabetes			Mental Illness		
Emphysema			Stroke/Paralysis		
Epilepsy (fits, seizures, convulsions)			Rheumatic fever		
Glaucoma			Ulcers		
Gall Bladder problems/Gall stones			Bowel Disorders/Colitis		
Venereal Disease			Other:		
Pneumonia/Pleurisy					

4. SURGICAL HISTORY

SURGERY	YEAR	HOSPITAL

5. FAMILY HISTORY

Are you adopted? Yes No

To the best of your knowledge, please list any diseases that run in your family (i.e. heart disease, high blood pressure, diabetes, breast/ovarian/prostate cancer, etc.)

RELATIONSHIP	ILLNESS

6. SOCIAL HISTORY

HABITS			
Smoking	Yes	No	Packs per day:_____________ Years:____________
Alcohol	Yes	No	Drinks per day:____________ Drinks per week:_______________
Drug Use	Yes	No	
Do you follow a special diet?	Yes	No	Please specify:____
Do you exercise	Yes	No	Hours per day:_____________ Days per week:_________________
Do you wear your seatbelt?	Yes	No	Sometimes

PROFILE	
Martial Status: ___Single ___Married ___Widowed ___Divorced	School Completed: ___High School ___College ___Graduate Degree ___Other
Number of living children:___________________	
Number of people in household:_______________	Current Occupation:____

7. HEALTH RISKS

Have you had your cholesterol checked within the last 5 years?	Yes	No	Year:____________ Result:____________
Have you had your stool checked for blood within the last year?	Yes	No	
Have you had a sigmoidoscopy (intestine exam) within the last 3-5 years?	Yes	No	

WOMEN ONLY			
Have you had a Pap Smear within the last 3 years?	Yes	No	Year:__________________
Have you ever had an abnormal pap smear?	Yes	No	If yes, when?_______________
Have you had a mammogram?	Yes	No	Date of last mammogram:_________________
Do you perform self-breast exams?	Yes	No	

MEN ONLY			
Have you had a prostate exam?	Yes	No	Year:_______________

Completed by: Patient Nurse Physician

Signature of Patient:______________________________________