Spring Valley Family Medicine History Short Form Please complete both sides!

Name	Date of birth		
What name do you prefer we address	you by?		
What is the reason for your visit today	y?		
Please list any significant medical problems Medical Prob			
Medical Prob	olem	Date Diagnosed	
List any operations you have had an	d the approximat	to data of surgery	
Operation	• •	Date	
opoliulio.			
Do you have any allergies to any medif YES , what medications and what pr	ications? Yes oblem did you ha	No O	
When was your last menstrual period? N/A			
Please list ANY medications - prescribincluding strength of medication and Include supplements, herbs and vita	number of times p		
Name of Medicine	Strength (mg)	Schedule you take it (times per day)	
-			

<u>Family History</u>: Please fill in as much history as possible below for parents, grandparents, siblings, and your children where applicable.

Family Member	Approx Year of Birth	Age at Death	Serious Health Problems / Cause of Death
Mother			
Mother's Dad			
Mother's Mom			
Father			
Father's Dad			
Father's Mom			

Social History

Occupation:
Education level:
Do you currently smoke (cigarettes, marijuana, hookah, e-cigarettes)? Yes No If YES, what do you smoke and how much?
If NO, have you ever smoked regularly? Yes No No If YES, how many packs/day (or other units of measurement) over how many years?
Average weekly alcohol consumption:
Do you use any recreational drugs? If so, what and frequency?
Frequency and type of exercise:
With whom do you live?
Do you feel safe at home?
Are there any major financial constraints upon your life?
Please list the name, address and phone number of your preferred pharmacy (if you have one):