BAPTIST PRIMARY CARE - KINGSLAND
PAST PATIENT FAMILY AND SOCIAL HISTORY FORM

DATE _____ PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ALLERGIES: NONE ☐ LIST ALLERIES _____ EXERCISE _____ DAILY ACTIVITIES _____

MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ LIVING ARRANGE _____ MOST RECENT OCCUPATION _____

OF CHILDREN _____ # OF PREGNANCIES _____ SMOKING: YES ☐ NO ☐ HOW MUCH PER DAY? _____ HOW LONG? _____ YRS

ALCOHOL: HOW MUCH PER DAY? _____ CAFFEINE (COFFEE, TEA, COLAS) HOW MUCH? _____

ILLICIT DRUG USE: NONE ☐ CURRENTLY USING _____ PRIOR PROBLEMS? YES ☐ NO ☐ EXPLAIN _____

PLEASE LIST ALL PAST SURGERIES WITH DATES

PLEASE LIST ALL PERSONAL ILLNESSES/INJURIES AND DATES

FAMILY HISTORY: (CHECK *ONLY* THOSE BOXES THAT ARE POSITIVE) ☐ DIABETES ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ T.B. ☐ CANCER ☐ KIDNEY DISEASE ☐ ANEMIA ☐ ARTHRITIS ☐ MENTAL ILLNESS

PLEASE EXPLAIN BOXES THAT ARE CHECKED _____

MOTHER ☐ LIVING ☐ DECEASED AGE _____ FATHER ☐ LIVING ☐ DECEASED AGE _____

CAUSE OF DEATH _____ CAUSE OF DEATH _____

REVIEW OF SYSTEM - PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	YES	NO
WEIGHT LOSS	☐	☐
FATIGUE	☐	☐
FEVER	☐	☐

EYES	YES	NO
GLASSES/CONTACTS	☐	☐
PAIN	☐	☐
DOUBLE VISION	☐	☐
GLAUCOMA	☐	☐
CATARACTS	☐	☐

EAR, NOSE, THROAT	YES	NO
DIFFICULTY HEARING	☐	☐
RINGING IN EARS	☐	☐
VERTIGO	☐	☐
SINUS TROUBLE	☐	☐
NASAL STUFFINESS	☐	☐
FREQUENT SORE THROAT	☐	☐
HOARSENESS	☐	☐

CARDIOVASCULAR	YES	NO
MURMUR	☐	☐
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
DIZZINESS	☐	☐
FAINTING SPELLS	☐	☐
SHORT OF BREATH	☐	☐
DIFFICULTY LYING FLAT	☐	☐
SWELLING ANKLES/OTHER	☐	☐

RESPIRATORY	YES	NO
COUGH	☐	☐
COUGHING BLOOD	☐	☐
WHEEZING	☐	☐
CHILLS	☐	☐

GASTROINTESTINAL	YES	NO
HEARTBURN	☐	☐
NAUSEA/VOMITING	☐	☐
CONSTIPATION	☐	☐
CHANGE IN BOWEL MOV.	☐	☐
DIARRHEA	☐	☐
DIFFICULT SWALLOWING	☐	☐
JAUNDICE	☐	☐
ABDOMEN PAIN	☐	☐
BLACK BM	☐	☐

GENITOURINARY	YES	NO
PAIN URINATING	☐	☐
BURNING	☐	☐
FREQUENCY	☐	☐
NIGHTTIME	☐	☐
BLOOD IN URINE	☐	☐
DIFFICULTY URINATING	☐	☐
HISTORY OF KIDNEY STONE	☐	☐
HISTORY STD	☐	☐
ABNORMAL DISCHARGE	☐	☐

FEMALE ONLY:	YES	NO
AGE OF ONSET PERIODS _____		
AGE OF ONSET MENPAUSE _____		
ARE PERIODS REGULAR?	☐	☐

HEMATOLOGIC/LYMPH	YES	NO
EASY BRUISING	☐	☐
GUMS BLEED EASILY	☐	☐
ENLARGED GLANDS	☐	☐
PROLONGED BLEEDING	☐	☐

MUSCULOSKELETAL	YES	NO
JOINT PAIN/SWELLING	☐	☐
STIFFNESS	☐	☐
MUSCLE PAIN	☐	☐
BACK PAIN	☐	☐

SKIN	YES	NO
RASH/SORES	☐	☐
LESIONS	☐	☐
ITCHING/BURNING	☐	☐

NEUROLOGICAL	YES	NO
SEIZURES	☐	☐
WEAKNESS/PARALYSIS	☐	☐
NUMBNESS	☐	☐
TREMORS	☐	☐
MEMORY LOSS	☐	☐

ENDOCRINE	YES	NO
LOSS OF HAIR	☐	☐
HEAT/COLD INTOLERANCE	☐	☐
CHANGE IN NAILS	☐	☐

ALLERGIC/IMMUNOLOGIC	YES	NO
HAY FEVER/ASTHMA	☐	☐
HIVES/ECZEMA	☐	☐

PSYCHIATRIC	YES	NO
ANXIETY/DEPRESSION	☐	☐
MOOD SWINGS/DIFFICULT SLEEP	☐	☐

SIGNATURE STAFF MEMBER REVIEW FOR COMPLETION _____