Caring for the Family
Jan Hester, MD

Preventive Health History Date:_____

Patient Name:_____ DOB:_____

Marital Status:_____ Occupation:_____

Reason for appointment:_____

Current/Chronic Health Issues:_____

Current Medications (include dosage):_____

_____

Supplements:_____

Known Drug Allergies:_____

Preferred Pharmacy (include location):_____

Hospital Admission/Surgeries: Year Surgery/Reason

_____

_____

_____

Current or Former Medical Issues Involving:

Eyes, Ears, Nose or Throat:_____ Respiratory:_____

Cardiac:_____ Gastrointestinal:_____

Genitourinary:_____ Psychiatric:_____

Musculoskeletal:_____ Neurologic:_____

Endocrine:_____ Sexual:_____

Do you exercise: Y/N Exercise performed:_____ Frequency:_____

Tobacco Use: Y/N Age of Onset:_____ Frequency:_____ Year Quit:_____

Alcohol Use: Y/N Frequency:_____ Drugs:_____

Do you snore: Y/N Have you been told you stop breathing during sleep: Y/N

Are you excessively tired during the day: Y/N Do you have history of high blood pressure: Y/N

Immunizations: Please circle and indicate date received

Td/Tdap _____ HepA_____Hep B_____ Gardasil/HPV _____ Flu shot_____
Pneumovax_____ TB test _____Pos/Neg

Preventive care: Please circle and indicate date received

DEXA (bone density)_____ Colonoscopy _____ Prostate Screening _____

Date of last eye exam:_____ Date of last dental exam:_____

Females Only:
Date of last pap:_____ History of abnormal pap Y/N Type of findings: _____

Type of treatment:_____ Date of last mammogram:_____

Date of last menstrual cycle:_____ Days of flow: _____ Length of cycle:_____

Regular/Irregular If irregular how: _____Clots/Cramps_____

Birth control method:_____ Hormone replacement therapy:_____

Number of pregnancies:_____ Live births____ Miscarriages_____ Abortions_____

Family History: Name Living/Deceased Cause of Death Hereditary Illnesses
Father:_____

Mother:_____

Sisters/Brothers:_____

_____

_____

Children:_____

_____

_____

Spouse: _____