Central Family Practice
720 W. 34th Street, Suite 105
Austin, TX 78705
(512)371-9260

Name	Date:	Age:

Medical History

Have you had or do you have any of the following:
(Please circle)

Alcoholism/substance abuse
Allergies
Anxiety
Asthma/emphysema
Arthritis
Blood in stool
Cancer
Chronic skin problems/rash
Colitis
Constipation
Depression
Diabetes
Diarrhea
Difficulty achieving orgasm
Difficulty swallowing
Diverticulitis
Double/blurred vision
Epilepsy/seizures
Exposure to HIV
Frequent or severe headaches
Gall bladder problem
Heart attack
Heart disease
Hepatitis
Hernia (type) _____
High blood pressure
High cholesterol
Impotence
Kidney or bladder infection
Kidney stone
Loss of hearing
Loss of vision
Night sweats
Osteoporosis
Pneumonia
Positive TB skin test
Rheumatic fever
Sexually transmitted disease:
(circle if applicable)
Gonorrhea
Chlamydia
Syphilis
Herpes
HPV/warts
Sinus problems
Stroke
Swelling in legs or feet
Tuberculosis
Thyroid problems
Vomiting of blood
Weight loss/gain

Are you experiencing any health problems today? If so, please describe: _____

_____

_____

Please list any surgeries or hospitalization: _____

_____

_____

Please list any medication allergies: _____

_____

_____

Please list all medication/supplements that you are taking: _____

_____

_____

Have your parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	**Alcoholism/**	**Osteoporosis**
Cancer	**substance abuse**	**Depression**
Type _____	**Heart Disease**	**Sickle cell trait/disease**
Stroke	**Thyroid problems**	**High cholesterol**

Which of the following contraceptive methods have you used: (please circle)

IUD	**Foam**	**Other _____**
Diaphragm	**Vasectomy**	**None, same sex preference**
Birth control pills	**Tubal ligation**	**Natural family planning**
Condoms	**None**	

How long have you been with your current sex partner? _____

Sleeping Habits

Are you having difficulty sleeping?	**Yes**	**No**
Is stress in your life causing you to lose sleep?	**Yes**	**No**
Have your sleeping habits changed recently?	**Yes**	**No**

Eating Habits

Have you gained or lost a significant amount of weight recently?	**Yes**	**No**
If yes, how much? _____		
Are you concerned about your current eating habits?	**Yes**	**No**
Do you consider your diet healthy?	**Yes**	**No**
Are you having problems with over-eating?	**Yes**	**No**
Do you think you may have an eating disorder?	**Yes**	**No**

Personal Habits

Do you smoke cigarettes?	**Yes**	**No**	**How many per day? _____**
Do you have regular bowel movements?	**Yes**	**No**	**How often? _____**
Do you exercise regularly?		**Yes**	**No**
Do you drink alcohol?		**Yes**	**No**
Do you feel overly stressed in your daily life?		**Yes**	**No**
Are you currently experiencing any feeling of depression?		**Yes**	**No**

Have you recently experienced any events that increase your stress level? Please describe: _____

_____

Menstrual/Pregnancy History

Age of first period _____ **Usual interval between periods _____**

Usual length of period _____ days **Age of first intercourse: _____**

Are you currently trying to get pregnant? Yes No

Number of:

Pregnancy: _____ **Abortion/miscarriage: _____**

Still births: _____ **Full-term deliveries: _____**

Have you had any of the following: (please circle)

Irregular periods	**Abnormal breast lumps**	**Infection in fallopian tubes**
Painful periods	**Abnormal pap smear**	**Ovarian cysts**
Infection in ovaries	**DES exposure**	