

RAU FAMILY MEDICINE

Date: _____

PATIENT SOCIAL HISTORY

Parents: Have you signed our minor consent form for your children? yes no Initials _____

Name: _____ DOB: _____ Soc. Sec. #: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse (parent) name: _____ Employment: _____

In case of emergency contact: _____ Phone #: _____

Birth History: vaginal delivery c-section Complications: _____

Where were you born? _____ Obstetrician: _____ Pediatrician: _____

Marital Status:

Single; Significant other? yes no; If yes: _____ Name of significant other: _____

Married #1 Date _____; #2 Date _____; #3 Date _____.

Divorced #1 Date _____; #2 Date _____; #3 Date _____.

Widowed #1 Date _____; #2 Date _____; #3 Date _____.

Religion/Church Affiliations: _____

Education: Did you attend pre-school?: yes no What is the highest level of education you have completed?

some high school high school graduate college or technical degree post graduate college

Last School attended _____

Military: _____ Stationed: _____

• Please list employment in chronological order starting with your current/most recent employment.

Note: For those under 18 yrs. include parents occupations. Designate mother = M, father = F.

Employment	Start	End	Job Description	Health / Safety Risks
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Insurance: Primary; _____ Secondary; _____

Deductible: _____ Co-insurance / Co-payment: _____

Network Limitation: yes no Point of Service Agreement: yes no

Community / School Activities: _____

Any recent situational stressors or major life changes?: _____

Children Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
 Functional Status: Dependent = D, Independent = I.

Sibling Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
 Functional Status: Dependent = D, Independent = I.

Parents: Are they?: never married married divorced remarried / father remarried / mother
 Date: _____ Date: _____ Date: _____ Date: _____

Are they dependent or independent? If dependent, why? _____

Do you have grandparents living? yes no

If yes, are they dependent or independent? If dependent, why? _____

Do you have grandchildren? yes no

If yes, are they dependent or independent? If dependent, why? _____

Are there others with whom you relate closely and share personal experiences? no yes Who: _____

If yes, are they dependent or independent? If dependent, why? _____

Secondary Caregivers for Children, Parents or Spouse:

Name	Location	Sex	Type*	For Whom?
1. _____				
2. _____				
3. _____				

Type of caregiver: Baby-sitter = B; Day Care = D; Home Health Aid = A; Nurse = N.

Have you made a living will? yes no Have you assigned a Health Care Representative? yes no

NAME:

INSTRUCTIONS: PUT ✓ IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

BIOLOGIC AND PSYCHOLOGIC FAMILY HISTORY

M - MATERNAL GM - GRANDMOTHER	P - PATERNAL GF - GRANDFATHER	MOTH	FATH	M GM	M GF	P GM	P GF	BROTHER				SISTER				SPOUSE	CHILDREN			
								1	2	3	4	1	2	3	4		1	2	3	4
AGE (IF LIVING)																				
HEALTH (G) GOOD (B) BAD																				
CANCER																				
TUBERCULOSIS																				
DIABETES																				
HEART TROUBLE																				
HIGH BLOOD PRESSURE																				
STROKE																				
EPILEPSY																				
ALCOHOL DEPENDENCE																				
NERVOUS BREAKDOWN																				
ASTHMA, HIVES, HAYFEVER																				
BLOOD DISEASE																				
OTHER																				
AGE (AT DEATH)																				
CAUSE OF DEATH																				
DATE OF DEATH (MO/YR)																				

PERSONAL HISTORY

HAS YOUR CHILD EVER HAD ...	DATE	NO	YES	HAS YOUR CHILD EVER HAD ...	DATE	NO	YES	HAS YOUR CHILD EVER HAD ...	DATE	NO	YES
<input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> SCARLATINA				SEVERE DIAPER RASH				ANY <input type="checkbox"/> BROKEN <input type="checkbox"/> CRACKED BONES			
<input type="checkbox"/> CONJUNCTIVITIS <input type="checkbox"/> WARTS				ANEMIA				RECURRENT DISLOCATIONS			
REYES SYNDROME				JAUNDICE				<input type="checkbox"/> CONCUSSION <input type="checkbox"/> HEAD INJURY			
PNEUMONIA				EPILEPSY				EVER BEEN KNOCKED UNCONSCIOUS			
PLEURISY				MIGRAINE HEADACHES				<input type="checkbox"/> FOOD <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DRUG POISON.			
MONO				URINARY TRACT INFECTIONS				EXPLAIN			
<input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HEART DISEASE				DIABETES							
ST. VITUS DANCE				CANCER							
<input type="checkbox"/> ARTHRITIS <input type="checkbox"/> RHEUMATISM				<input type="checkbox"/> HIGH <input type="checkbox"/> LOW BLOOD PRESSURE				ANY OTHER DISEASE			
ANY <input type="checkbox"/> BONE <input type="checkbox"/> JOINT DISEASE				SIGNIFICANT BEHAVIOR PROBLEM				EXPLAIN			
<input type="checkbox"/> NEURITIS <input type="checkbox"/> NEURALGIA				<input type="checkbox"/> HAY FEVER <input type="checkbox"/> ASTHMA <input type="checkbox"/> ALLERGIES							
<input type="checkbox"/> BURSTITIS <input type="checkbox"/> SCIATICA <input type="checkbox"/> LUMBAGO				<input type="checkbox"/> HIVES <input type="checkbox"/> ECZEMA							
<input type="checkbox"/> POLIO <input type="checkbox"/> MENINGITIS				FREQUENT <input type="checkbox"/> COLDS <input type="checkbox"/> SORE THROAT				WEIGHT: NOW	ONE YR. AGO		
STROKE OR CEREBRAL PALSY				FREQUENT <input type="checkbox"/> INFECTIONS <input type="checkbox"/> BOILS				MAXIMUM	WHEN		

SURGERIES & HOSPITALIZATIONS

REMOVED ...	SURGEON	DATE	NO	YES	REMOVED ...	SURGEON	DATE	NO	YES	HAS YOUR CHILD ...	SURGEON	DATE	NO	YES
<input type="checkbox"/> TONSILS <input type="checkbox"/> ADENOIDS					CIRCUMCISION					HAD A HERNIA REPAIRED?				
APPENDIX					MOLE REMOVAL					HAD ANY OTHER OPERATIONS?				
GALL BLADDER					TRANSFUSION ...					BEEN HOSPITALIZED FOR ANY ILLNESS?				
<input type="checkbox"/> UTERUS <input type="checkbox"/> OVARY <input type="checkbox"/> OVARIES					<input type="checkbox"/> BLOOD <input type="checkbox"/> PLASMA					PLEASE EXPLAIN BELOW NOTING DATES, SURGEONS, PHYSICIANS, & HOSPITALS				

DIAGNOSTIC STUDIES

EVER HAD STUDIES OF ...	NO	YES	DATE	DISEASE PRESENT
CHEST <input type="checkbox"/> XRAY <input type="checkbox"/> CAT SCAN				
STOMACH <input type="checkbox"/> XRAY <input type="checkbox"/> ENDOSCOPY				
COLON <input type="checkbox"/> XRAY <input type="checkbox"/> COLONOSCOPY				
GALL BLADDER <input type="checkbox"/> XRAY <input type="checkbox"/> ULTRASOUND				
EXTREMITIES <input type="checkbox"/> XRAY <input type="checkbox"/> MRI				
BACK <input type="checkbox"/> XRAY <input type="checkbox"/> CAT SCAN <input type="checkbox"/> MRI				
SIGMOIDOSCOPY				
<input type="checkbox"/> EKG <input type="checkbox"/> ECHO <input type="checkbox"/> TREADMILL				
OTHER				

ALLERGIES

IS YOUR CHILD ALLERGIC TO ...	DATE	NO	YES	IS YOUR CHILD ALLERGIC TO ...	DATE	NO	YES	IS YOUR CHILD ALLERGIC TO ...	DATE	NO	YES
<input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA DRUGS				ANY OTHER DRUGS				ANY FOODS			
<input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE				EXPLAIN				EXPLAIN			
<input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS											
<input type="checkbox"/> TETANUS <input type="checkbox"/> ANTITOXIN <input type="checkbox"/> SERUMS				ADHESIVE TAPE				<input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS			

BIOLOGIC REVIEW OF SYSTEMS

DOES YOUR CHILD HAVE OR EVER HAD ...	DATE	NO	YES	DOES YOUR CHILD HAVE OR EVER HAD ...	DATE	NO	YES
ANY <input type="checkbox"/> EYE DISEASE <input type="checkbox"/> EYE INJURY <input type="checkbox"/> IMPAIRED SIGHT <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS				KIDNEY <input type="checkbox"/> DISEASE <input type="checkbox"/> STONES			
ANY <input type="checkbox"/> EAR DISEASE <input type="checkbox"/> EAR INJURY <input type="checkbox"/> IMPAIRED HEARING <input type="checkbox"/> BRACES				BLADDER DISEASE			
ANY TROUBLE WITH <input type="checkbox"/> NOSE <input type="checkbox"/> SINUSES <input type="checkbox"/> MOUTH <input type="checkbox"/> THROAT				BLOOD IN URINE			
FAINTING SPELLS				<input type="checkbox"/> ALBUMIN <input type="checkbox"/> SUGAR <input type="checkbox"/> PUS <input type="checkbox"/> ETC. IN URINE			
<input type="checkbox"/> CONVULSIONS <input type="checkbox"/> PARALYSIS				DIFFICULTY IN URINATION			
<input type="checkbox"/> BONE PAIN <input type="checkbox"/> JOINT PAIN				NARROWED URINARY STREAM			
DIZZINESS				ABNORMAL THIRST			
HEADACHES: <input type="checkbox"/> FREQUENT <input type="checkbox"/> SEVERE				<input type="checkbox"/> PROSTATE TROUBLE <input type="checkbox"/> TESTICLE TROUBLE			
ENLARGED GLANDS				<input type="checkbox"/> STOMACH TROUBLE <input type="checkbox"/> ULCER			
THYROID: <input type="checkbox"/> OVERACTIVE <input type="checkbox"/> UNDERACTIVE <input type="checkbox"/> ENLARGED				INDIGESTION			
ENLARGED GOITER				<input type="checkbox"/> GAS <input type="checkbox"/> BELCHING			
<input type="checkbox"/> SKIN DISEASE <input type="checkbox"/> CHANGING MOLES				APPENDICITIS			
COUGH: <input type="checkbox"/> FREQUENT <input type="checkbox"/> PERSISTENT				<input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> GALL BLADDER DISEASE			
<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> WHEEZING				<input type="checkbox"/> COLITIS <input type="checkbox"/> OTHER BOWEL DISEASE			
SPITTING UP BLOOD				<input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> RECTAL BLEEDING			
NIGHT SWEATS				BLACK TARRY STOOLS			
SHORTNESS OF BREATH <input type="checkbox"/> EXERTION <input type="checkbox"/> AT NIGHT				<input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA			
<input type="checkbox"/> PALPITATION <input type="checkbox"/> FLUTTERING HEART				<input type="checkbox"/> PARASITES <input type="checkbox"/> WORMS			
SWELLING OF <input type="checkbox"/> HANDS <input type="checkbox"/> FEET <input type="checkbox"/> ANKLES				<input type="checkbox"/> ANY CHANGE IN APPETITE <input type="checkbox"/> EATING HABITS			
BIRTH MARKS				<input type="checkbox"/> ANY CHANGE IN BOWEL ACTION <input type="checkbox"/> STOOLS			
EXTREME <input type="checkbox"/> TIREDNESS <input type="checkbox"/> WEAKNESS				EXPLAIN			

PSYCHOLOGICAL & EMOTIONAL REVIEW OF SYSTEMS

HAS YOUR CHILD BEEN ...	DATES	NO	YES	HAS YOUR CHILD BEEN ...	DATES	NO	YES
DEPRESSED				HAVE YOU EVER BEEN INVOLVED IN COUNSELING FOR OR WITH YOUR CHILD			
ANXIOUS				OTHER TREATMENTS (I.E. BIOFEEDBACK)			
IRRITABLE				IS CONCENTRATION DIFFICULT FOR YOUR CHILD			
JUMPY				HAS YOUR CHILD EVER RELATED SUICIDE THOUGHTS			
JITTERY				HAS YOUR CHILD EVER RELATED A SUICIDE PLAN			

WOMEN ONLY

MENSTRUAL HISTORY ...	NO	YES
AGE AT ONSET ANY RECENT CHANGE IN CYCLE		
DATE OF LAST PERIOD		
USUAL DURATION OF PERIOD DAYS		
CYCLE (START TO START) DAYS		
ARE YOU REGULAR: <input type="checkbox"/> HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT		
DO YOU HAVE <input type="checkbox"/> TENSION <input type="checkbox"/> DEPRESSION BEFORE PERIOD		
DO YOU HAVE <input type="checkbox"/> CRAMPS <input type="checkbox"/> PAIN WITH PERIOD		
DO YOU HAVE HOT FLASHES		

IMMUNIZATION AND INFECTION RISK

HAS YOUR CHILD HAD ...	DATE	NO	YES	HAS YOUR CHILD HAD ...	DATE	NO	YES
DIPHTHERIA, PERTUSIS & TETANUS (DPT) SHOTS				MEASLES ILLNESS			
HEMOPHILUS INFLUENZA B (HIB) SHOTS				MUMPS ILLNESS			
MEASLES, MUMPS, RUBELLA (MMR) SHOTS				CHICKEN POX			
POSTIVE TB SKIN TEST				PNEUMONIA SHOTS			
TETANUS SHOT (NOT ANTITOXIN)				OTHER IMMUNIZATIONS			
POLIO IMMUNIZATION							

LIFESTYLE AND MEDICATION

DOES YOUR CHILD ...	NO	YES	DOES YOUR CHILD USE ...	NEVER	OCC.	FREQ.	DAILY
EXPLORE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES OR SLEEPING PILLS				
SLEEP WELL			HYPERACTIVITY MEDICINE OR ANTI DEPRESSANTS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			TYLENOL				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRIN				
COMFORT EASILY			CORTISONE				
<input type="checkbox"/> HAVE SUCCESS IN SCHOOL <input type="checkbox"/> ATTEND PRE-SCHOOL			MILK				
WATCH TELEVISION (HOURS PER DAY)			<input type="checkbox"/> COFFEE <input type="checkbox"/> TEA (CUPS PER DAY)				
READ (HOURS PER DAY)			CAFFEINATED SOFT DRINKS				
STAY AT DAYCARE OR WITH A BABYSITTER (HOURS PER WEEK)			DECAFFEINATED SOFT DRINKS				
EAT A WELL-BALANCED DIET			TOBACCO PRODUCTS				
BLEND EASILY WITH HIS / HER PEER GROUP			CHOCOLATE				
PARTICIPATE IN SPORTS OR HAVE HOBBIES (HOURS PER WEEK)			APPETITE DEPRESSANTS				
USE ANY EDUCATIONAL AIDS OUTSIDE OF SCHOOL			THYROID MEDICATION: <input type="checkbox"/> NO <input type="checkbox"/> YES, IN PAST <input type="checkbox"/> NONE NOW <input type="checkbox"/> NOW ON <input type="checkbox"/> GR. DAILY				
<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFTHANDED <input type="checkbox"/> BOTH			OTHER MEDICATION:				