

TEPEYAC FAMILY CENTER

Name _____ S M W D SEP (Circle) Date _____
 Address _____ City _____ State _____ Zip _____
 Telephone (H) (____) _____ (O) (____) _____ Date of Birth ____/____/____ Age _____
 Occupation/Employer _____ Religion (optional) _____

Family History	Living Health		Deceased Health		Has any relative ever had:	
	Age		Age		Yes	Who?
Father					Cancer	<input type="checkbox"/>
Mother					Alcoholism	<input type="checkbox"/>
Brother/Sister 1					Diabetes	<input type="checkbox"/>
2					Heart trouble	<input type="checkbox"/>
3					High Blood Pressure	<input type="checkbox"/>
4					Stroke	<input type="checkbox"/>
5					Epilepsy	<input type="checkbox"/>
Husband (if Married)					Thyroid Disease	<input type="checkbox"/>
Son/Daughter 1					Female Surgery	<input type="checkbox"/>
2					Cesarean-section	<input type="checkbox"/>
3					Kidney Trouble	<input type="checkbox"/>
4					Overweight	<input type="checkbox"/>
5					Sickle Cell	<input type="checkbox"/>
6					Miscarriages/Abortions	<input type="checkbox"/>
7					Congenital Problems/Twins	<input type="checkbox"/>

Menstrual History Age at onset ____; Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No Cycle ____ days (from start to start) Days of Bleeding ____ First day of last period ____/____/____ Flow <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy Menstrual Pains or PMS? <input type="checkbox"/> Yes <input type="checkbox"/> No Use <input type="checkbox"/> Pads <input type="checkbox"/> Tampons Age at 1 st Pelvic Exam ____ Pain/Bleeding during or after sex? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Pregnancies (include miscarriages, stillbirths & abortions)						
	Name	Year	Weight	Sex	Hrs of Labor	Anesthesia	Complications

Year	Surgeries	List all Medications You Are Now Taking	Drug Allergies

Height _____ Weight _____/Current _____/1 year ago _____/Highest _____/When _____

- | Check Box if you have ever had: | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head injury/fainting spells/convulsions | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Headaches, frequent/severe | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches, migraine | <input type="checkbox"/> Oral Contraceptive Pills (taking) |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chest Pain (or spitting up of blood) | <input type="checkbox"/> High/Low blood Pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV | <input type="checkbox"/> Rectal bleeding, constipation/diarrhea |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chronic/Frequent Cough | <input type="checkbox"/> I. U. D. | <input type="checkbox"/> STD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Ear disease/injury/impaired hearing | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Eye disease/injury/impaired sight | <input type="checkbox"/> Kidney/bladder disease | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Fatigue, chronic | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Swelling of hands/feet/ankles |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Loss of urine with cough/sneeze | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Trouble with nose, sinuses, mouth, throat |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Natural Family Planning (use of) | |
| | <input type="checkbox"/> Mucus <input type="checkbox"/> Temps | |

Alcohol _____ oz. per week
 Smoking _____ cig. per day _____ # years
 Coffee/Tea/Soda _____ cups/day
 Date of last PAP test ____/____/____
 Date of last mammogram ____/____/____
 Age at menopause _____

COMMENTS:

