Office of Family Nurse Practitioner Laura Hudson FNP-C
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MEDICAL HISTORY - FIRST VISIT

Date_______________

Legal Name _______________________________ Preferred Name _______________ DOB ______________

Gender assigned at birth: M / F Gender Identity (if different):____

MEDICAL HISTORY: *Indicate **past** (P) or **current** (C) next to each applicable condition below or blank if N/A*

__ Heart Disease	__ Hepatitis	__ Headache	__ Anxiety	__ Mono
__ Lung Disease	__ Hernia	__ Sinus Problem	__ Panic Attacks	__ Lyme Disease
__ Liver Disease	__ Asthma	__ Eye Problem	__ Depression	__ Fibromyalgia
__ Kidney Disease	__ Emphysema	__ Ear Problem	__ Suicide Attempt	__ Chronic Fatigue
__ Thyroid Disease	__ Ulcers / GERD	__ Mouth Problem	__ Trouble Sleeping	__ Arthritis OA/RA
__ Diabetes	__ High Cholesterol	__ TMJ Problem	__ Restless Leg	__ Carpal Tunnel
__ Seizures	__ Blood Disease	__ Neck Problem	__ Trauma	__ MRSA
__ Stroke	__ Cancer	__ Bone Disease	__ Skin Lesions	__ Eczema/ Psoriasis

__ Urinary Issues: __ leaking __ frequency __ urgency __ blood __can't empty __weak stream

Other: ____

Elaborate on above: ____

____

ALLERGIES: Penicillin Sulfa E-mycin Cephalosporins Morphine Aspirin Codeine NSAIDs

Other meds:____

Latex Y / N Tape/Adhesive Y / N Iodine Y / N Shellfish Y / N Bees Y / N Nuts Y / N

Environmental ____

Food / Intolerances ____

SCREENING TESTS: *(when was the last time you had one done?)*

PCP Physical_________________ GYN Exam__________________ Pap Smear ________ HPV___________

Mammogram ________________ Bone Density _________________ Routine Blood Work ________________

Colonoscopy ____________= wnl / polyps / cancer = Planned next at: 3 yr / 5yr / 10 yr interval

Ultrasound __________ Stress Test ____________ EKG___________ Other ____________________________

IMMUNIZATION HISTORY:

Childhood Immunizations Complete? Y /N If No, What is missing:___________________________________

Did you have the Chickenpox Y /N If No, did you receive the Vaccine Y / N Titer?____________________

Zostavax Vaccine (Shingles) Y / N Date:_________ Last Flu Shot Date:________ HPV Y / N Date:_________

Pneumovax Vaccine (pneumonia) Y / N Date:__________ Prevnar 13 Vaccine (pneumonia) Y / N Date:_________

Medications	**Dose**	**Times/Day**	**Reasons**

Multivitamin ______ Calcium mg/day ______ Vitamin D # IU/day ______ Iron_______ Probiotic_____ Magnesium________

Updated 1/20

SEXUAL HEALTH:

Sexual Orientation:__________________ Practicing safe sex: Y / N Contraception?___________________

Hx Sexually Transmitted Infection: __HPV __Warts __Herpes __Chlamydia __Gonorrhea __Syphilis __HIV

Sexual Concerns? Y / N __no desire __no pleasure __ orgasm issue __ impotence __dryness __pain

GYNECOLOGY HISTORY: (if applicable)

Total Pregnancies _______ Live Births _______ Miscarriages/Terminations ________ #Living Kids ________

Age Periods Began__________ Age Periods Ended__________ Hyst? Y / N Ablation Y / N

Regular Periods? Y / N Happen how often ___________________ Last how long ___________________

Abnormally Heavy_____ Abnormally Painful ______ Bleed Between Periods______ Bleed After Sex _____

History Abnormal Paps: Y / N When _______ Diagnosis ______________ Treatment ___________________

Vag Symptoms *(itch, pain, burn)* _____________________________________ Abn Discharge _______________

PMS: Y / N PMDD Y / N Hot Flashes / Night Sweats Y / N

FAMILY HISTORY: ****Check applicable boxes*** # Children: ____living ____deceased

Relative	age of death	Heart Disease	Diabetes	Stroke	Heart Attack	AFib	^ BP	^ Cholesterol	Thyroid	Cancers (type)
Mother										
Father										
Maternal G-Parents										
Paternal G-Parents										
Sisters										
Brothers										
Aunt/Uncle										
Children										

SURGICAL HISTORY:

Surgery ____________________________________ Year __________ Where __________________________

Surgery ____________________________________ Year __________ Where __________________________

Surgery ____________________________________ Year __________ Where __________________________

Surgery ____________________________________ Year __________ Where __________________________

OTHER PROVIDERS: **Ok to share info?** **Initial**

PCP (if not here) __________________________________ Location ______________________ Y / N ______

Psychotherapist ________________________________ Location ______________________ Y / N ______

Gynecologist __________________________________ Location ______________________ Y / N ______

Massage Therapist ________________ Chiropractor __________________ Acupuncturist ________________

Other ______________________________________ Other _______________________________________

LIFE STYLE:

Have a *living will* Y / N Medical *DPA* Y / N -who if yes________________________Ph#_________________

Who lives with you____ Pets _________________________

Occupation ____Like Work? __________________

Exercise ___________________ Frequency ______________ # meals/day ________ # veggie servings/day ______

Caffeine/day _________ Alcohol/day ___________ Street drugs? ___________________ any ever ______________

Tobacco: Y / N type___________how much / often ______________ for how long__________ want to quit ________

Prior Smoker _________ Quit when ___________ Sleep Well ____________ Need meds to sleep_________________

Safe at Home ______________ History of Physical, Emotional or Sexual Abuse ______________________________

Updated 1/20