

Alliance Family Practice  
DATA BASE TOOL  
Interim Medical and Personal History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: M / F Race: \_\_\_\_\_

For what reason are you here today? \_\_\_\_\_  
\_\_\_\_\_

Have you developed any new medical problems since your last visit?

NO  YES (please explain below)

New Medical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen any other physicians or practitioners since your last visit?

NO  YES (please explain below)

Other medical visits: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgical procedures since your last visit?

NO  YES (please explain below)

New Surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate if you had any of the following preventative tests or services since your last visit:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Cardiac Angiogram | <input type="checkbox"/> Flu Vaccine       | <input type="checkbox"/> Prostate Cancer Blood   | <input type="checkbox"/> Mammogram / Breast Exam    |
| <input type="checkbox"/> Stress Test       | <input type="checkbox"/> Pneumonia Vaccine | <input type="checkbox"/> Rectal Exam             | <input type="checkbox"/> Pap Smear                  |
| <input type="checkbox"/> Echocardiogram    | <input type="checkbox"/> Tetanus Vaccine   | <input type="checkbox"/> Colon cancer Stool Test | <input type="checkbox"/> Date of Last Physical Exam |
| <input type="checkbox"/> Chest X-ray       | <input type="checkbox"/> Hepatitis Vaccine | <input type="checkbox"/> Flexible Sigmoidoscopy  | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> EKG               | <input type="checkbox"/> Bone Density Test | <input type="checkbox"/> Barium Enema            | _____   |

Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any new allergies or intolerance to drugs or other substances you have noted since your last visit:

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Please list any new medications or changes in medications since your last visit:

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Doctor's Notes:

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**FAMILY MEDICAL HISTORY:**

Have any of the following medical conditions occurred in your family since your last visit?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Breast Cancer   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Thyroid Disease   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Ovarian Cancer  |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Colon Cancer    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                 | <input type="checkbox"/> _____           |

Notes:

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Doctor's Notes:

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**PERSONAL INFORMATION:**

Have there been any changes in your personal information since your last visit?

Occupation: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Smoking / Tobacco Use: \_\_\_\_\_

Caffeine or soda consumption: \_\_\_\_\_

Alcohol consumption: \_\_\_\_\_

Substance abuse: \_\_\_\_\_

Sexual orientation :      Not sexually active                      Heterosexual                      Homosexual / Bisexual

Are you on a special diet? \_\_\_\_\_

How much do you exercise? \_\_\_\_\_

Do you have pets? \_\_\_\_\_

Doctor's Notes:

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