

**Central Family Practice**  
 801 W. 34<sup>th</sup> Street, Suite 102  
 Austin, TX 78705  
 (512)371-9260

Name _____	Date: _____	Age: _____
------------	-------------	------------

**Medical History**

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

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>Alcoholism/substance abuse</li> <li>Allergies</li> <li>Anxiety</li> <li>Asthma/emphysema</li> <li>Arthritis</li> <li>Blood in stool</li> <li>Cancer</li> <li>Chronic skin problems/rash</li> <li>Colitis</li> <li>Constipation</li> <li>Depression</li> <li>Diabetes</li> <li>Diarrhea</li> <li>Difficulty achieving orgasm</li> <li>Difficulty swallowing</li> <li>Diverticulitis</li> <li>Double/blurred vision</li> </ul> | <ul style="list-style-type: none"> <li>Epilepsy/seizures</li> <li>Exposure to HIV</li> <li>Frequent or severe headaches</li> <li>Gall bladder problem</li> <li>Heart attack</li> <li>Heart disease</li> <li>Hepatitis</li> <li>Hernia (type) _____</li> <li>High blood pressure</li> <li>High cholesterol</li> <li>Impotence</li> <li>Kidney or bladder infection</li> <li>Kidney stone</li> <li>Loss of hearing</li> <li>Loss of vision</li> <li>Night sweats</li> <li>Osteoporosis</li> </ul> | <ul style="list-style-type: none"> <li>Pneumonia</li> <li>Positive TB skin test</li> <li>Rheumatic fever</li> <li>Sexually transmitted disease:<br/>(circle if applicable)</li> <li style="padding-left: 20px;">Gonorrhea</li> <li style="padding-left: 20px;">Chlamydia</li> <li style="padding-left: 20px;">Syphilis</li> <li style="padding-left: 20px;">Herpes</li> <li style="padding-left: 20px;">HPV/warts</li> <li>Sinus problems</li> <li>Stroke</li> <li>Swelling in legs or feet</li> <li>Tuberculosis</li> <li>Thyroid problems</li> <li>Vomiting of blood</li> <li>Weight loss/gain</li> </ul> |
|---|---|---|

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/ substance abuse	Osteoporosis
Cancer	Heart Disease	Depression
Type _____	Thyroid problems	Sickle cell trait/disease
Stroke		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	