

Name _____ Date _____

Date of Birth _____

Religion _____ Education Level _____

Lone Star Family Health Center

704 Old Montgomery Rd
Conroe, Texas 77301

Have you, your spouse, or a "blood" relative ever had the following	Yourself		Relative		Relationship or Details	Doctor's Notes
	Yes	No	Yes	No		
Diabetes						
Thyroid problems						
Dizziness or fainting						
Heart Trouble or chest pain						
High blood pressure						
Asthma						
Hay fever or allergies						
Pneumonia						
Bowel / GI disorder						
Stomach ulcers						
Bleeding or blood disorder / Anemia						
Cancer						
Blindness or Glaucoma						
Deafness						
Neurologic disease(including Seizures)						
Stroke						
Depression						
Nervousnes						
Mental retardation						
Arthritis or bone Disorder			Hospitalizations/ Surgery		Year	
Sexual disorder						
Venereal Ddisease						
Chicken pox						
Hepatitis or jaundice						
Injuries other than strains or sprains						
Major or prolonged illness						
Blood transfusion						

Do you smoke or use oral tobacco?
 Yes ___ How long? _____
 No ___ Amount _____
 If quit, how long? _____

Do you have a history of substance abuse?
 Yes _____ No _____

Current Medications:
 (Please list all)

Do you drink Alcohol? _____
 Type _____ Amount _____

Coffee / other caffeine?
 Amount _____

Do you consider your lifestyle health-conscious?
 (exercise,salt, fat intake, etc.) _____

Drug allergies

FOR WOMEN ONLY:

Age periods began _____
 How long do they last _____
 How many days apart are they _____
 Menstrual problems _____

Number of pregnancies _____
 Number of miscarriages _____
 Number of children _____
 Planning children? _____

