Reyes Family Medicine

Name:	Date of Birth:	Age:	Occupation:

Have you ever had or now have a problem with:

	Yes	No		Yes	No		Yes	No
Anxiety / Depression			Heart Trouble			Migraines		
Asthma / Emphysema			Kidney Disease			Thyroid Disease		
Bleeding Tendencies			Mental Illness			Bleeding Disorder		
Blood Clots			Valley Fever			Chronic Back Pain		
Cancer			Arthritis			Other		
Diabetes			Seizures					
Glaucoma			Tuberculosis					
High Blood Pressure			STD's					
High Cholesterol			Stroke					

Family History	**Age(s)**	**Medical Problems**
Father		
Mother		
Brothers(s)		
Sister(S)		

Have you ever had an operation? **Yes** ☐ **No** ☐ **If Yes, please list:**

Year	Operation	Year	Operation	Year	Operation

List other illness NOT requiring an operation for which you were hospitalized:

Do you have any allergies or sensitivities to medicines or other substances? Yes ☐ **No** ☐ **If yes, please list with type of reaction:**

Do you have any religious or cultural beliefs which may affect your care with Reyes Family Medicine? Yes ☐ **No** ☐ **If yes, please explain:**

Medications name or otherwise identify over the counter. Herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advance Directive (Living Will) in place? Yes ☐ **No** ☐

Tobacco use now Y ☐ N ☐	Past Y ☐ N ☐	Type/Amount:	How long:
Alcohol use now Y ☐ N ☐	Past Y ☐ N ☐	Type/Amount:	How long:
Marijuana/drugs use now Y ☐ N ☐	Past Y ☐ N ☐	Type/Amount:	How long:

Check the disease against which you have been immunized: Hepatitis B ☐ **Hepatitis A** ☐ **Pneumovax** ☐ **MMR** ☐ **Tetanus** ☐ **Polio** ☐ **Diphtheria** ☐ **Influenza** ☐ **Other:**

Date of last Pap smear	Date of last Mammogram:
Number of Pregnancies	Number of live births:
Are you sexually active? Yes ☐ No ☐	Have you ever experienced any form of abuse? Y ☐ N ☐

Have you ever had a blood transfusion? Yes ☐ No ☐ Date:

Is there anything that you would like to discuss with your physician in confidentiality? Yes ☐ No ☐

Patient Signature: **Date:**

Physician/Provider Signature **Date:**