Family Medicine Associates of Northridge

Welcome to our office!

In order to provide you with quality care, we need to collect and confirm some basic information:

Last Name: _____ First Name: _____

Birth Date: ____/____/_____

Preferred Physician Contact#(_____) _____-_____**Preferred Language: _____**

Drug Allergies:

_____ _____ _____

ALL CURRENT MEDICATIONS

Current Medical Conditions:

_____

_____

_____

_____

Past Surgeries AND **Hospitalizations** AND **Major Illnesses**

____/____/_____ _____

____/____/_____ _____

____/____/_____ _____

____/____/_____ _____

____/____/_____ _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race:

□ American Indian or Alaskan Native □ Asian □ Black or African American

□ Pacific Islander or Native Hawaiian □ Caucasian □ Other

Please continue to other side ➔

SOCIAL HISTORY

Do you Smoke?	□ **YES**, everyday→ □ **YES**, some days→ □ **YES**, former but quit→ □ **NO**, never smoked	How many/How often? _____ When did you quit? _____
Do you drink alcohol?	□ **YES**→ □ **NO**	How many/How often? _____
Have you used any nonprescription drugs?	□ **YES,** current→ □ **YES,** past use→ □ **NO**	How many/How often? _____
Do you drink Coffee OR any other Caffeinated beverage?	□ **YES**→ □ **NO**	How many/How often? _____
Do you wear a seatbelt when driving? □ **YES** □ **NO**		Do you have a living will? □ **YES** □ **NO**

FAMILY HISTORY

LIVING?	**YES**	**NO**	**If deceased, list age & cause of death**
Mother	□	□	
Father	□	□	
Sibling(s)	□	□	

Anyone in your family diagnosed with:			If **YES**, then **WHO**? At what **AGE**
Heart Problems	□ **NO**	□ **YES**	
High Blood Pressure	□ **NO**	□ **YES**	
Cancer (specify)	□ **NO**	□ **YES**	
Diabetes	□ **NO**	□ **YES**	
Kidney Problems	□ **NO**	□ **YES**	
Thyroid Problems	□ **NO**	□ **YES**	
Arthritis	□ **NO**	□ **YES**	

Women Only

When was your last menstrual period? _____

Are your periods regular? □ **YES** □ **NO**

How many pregnancies have you had? _____

How many children have you delivered? _____