Northside Family Practice
960 Woodstock Pkwy, Suite 300
Woodstock, GA 30188
O: 770-517-2145 F: 770-517-2147

Patient Name: ______________________________ Date: ______________

PAST MEDICAL HISTORY

☐ No Medical Problems

Problem	Type/Comment	Problem	Type/Comment
☐ Acid Reflux/GERO		☐ Heart Disease	
☐ Anemia		☐ Hepatitis C	
☐ Anxiety		☐ HIV	
☐ Asthma		☐ High Cholesterol	
☐ Bleeding Disorder		☐ High Blood Pressure	
☐ Cancer		☐ Kidney Disease	
☐ COPD		☐ Liver Disease	
☐ Depression		☐ Migraines	
☐ Diabetes		☐ Sleep Apnea	
☐ Hayfever (Allergies)		☐ Thyroid Disease	

☐ Other ______________________________

PAST SURGICAL HISTORY

☐ No Previous Surgeries

Year	Type	Hospital/Doctor

HOSPITALIZATIONS

☐ No Previous Hospitalizations

Year	Type	Hospital/Doctor

FAMILY HISTORY

	Mother	Father	Sibling	Other		Mother	Father	Sibling	Other
☐ Allergies	☐	☐	☐	☐	☐ High Blood Pressure	☐	☐	☐	☐
☐ Asthma	☐	☐	☐	☐	☐ Migraines	☐	☐	☐	☐
☐ Bleeding Disorder	☐	☐	☐	☐	☐ Seizures	☐	☐	☐	☐
☐ Cancer: ______________________	☐	☐	☐	☐	☐ Stroke	☐	☐	☐	☐
☐ Depression/Anxiety	☐	☐	☐	☐	☐ Thyroid Problems	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐ Other: ______________________	☐	☐	☐	☐
☐ Heart Disease	☐	☐	☐	☐					

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS

Medication Name	Strength	Frequency Taken

MEDICATION AND FOOD ALLERGIES

☐ **No Medication Allergies** ☐ **Latex Allergy** ☐ **Iodine (Shellfish} Allergy**

Medication/Food	Type of Reaction	Medication/Food	Type of Reaction

SOCIAL HISTORY

Occupation	What do/did you do for work?	Are you retired? ☐ Yes ☐ No
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, what kind(s)?	
	How many per week?	Has anyone been concerned about your drinking? ☐ Yes ☐ No
Tobacco	Do/did you use tobacco? ☐ Yes ☐ No	Secondhand smoke exposure? ☐ Yes ☐ No
	Cigarettes – packs/day: Number of years:	Year quit:
Other	Do you currently use recreational or street drugs? ☐ Yes ☐ No	

Office Use Only

Reviewed by MD: ____ **Date:** ____________________