Greenville Family Medicine

Lifestyle Medicine Health History Form

GREENVILLE HEALTH SYSTEM

CONTACT INFO

Full name:	Age:	DOB:
Preferred name:	City & state of residence:	
Employer :		Occupation:
How did you hear about our Lifestyle Medicine practice?		
Was this form sent to you at least 5 days prior to your visit? [ ] YES [ ] NO		

PAST MEDICAL HISTORY

If your history is already in the GHS system, list only **big picture** items here (e.g. skip the broken arm, wart removal, etc.).

Congenital disorders (present at birth):

Significant injuries:

1		Date:
2		Date:
3		Date:

Hospitalizations:

1		Date:
2		Date:
3		Date:

Surgeries:

1		Date:
2		Date:
3		Date:

Previous medical diagnoses:

1		Date:
2		Date:
3		Date:
4		Date:
5		Date:
6+		Date:

Dental procedures and diagnoses:

1		Date:
2		Date:

REPRODUCTIVE HISTORY

How many children do you have?
If you have had difficulty conceiving or have undergone fertility treatment, please explain:

For females only:

How many pregnancies have you had?			
How many were...			
Vaginal deliveries?	C-sections?	Miscarriages?	Abortions?
I am: [ ] Having periods [ ] Other:	[ ] Beginning menopause	[ ] Through menopause	

FAMILY HISTORY

List significant illnesses, e.g. Alzheimer's, asthma, diabetes, cancer, cardiovascular or autoimmune disease in any family members and age at time of death, if applicable.

Maternal grandmother:	
Maternal grandfather:	
Paternal grandmother:	
Paternal grandfather:	
Mother:	
Father:	
Sisters:	
Brothers:	
Children:	

SOCIAL AND LIFESTYLE HISTORY

Relationship status:	
Sexual preference (men, women, or both):	
Currently sexually active?	

Tobacco use (specify type, quantity, and period of use):	
Alcohol use (specify type, quantity, and period of use):	
Drug use (specify type, quantity, and period of use):	
Caffeine use (specify type, quantity, and period of use):	

How many hours per week do you work?	
How many hours daily is your commute to work?	
List any significant occupational exposures:	

Current weight:		Height:	
Weight at age 18:		Heaviest lifetime weight:	
If applicable, have you been successful with weight loss in the past? How?			

Describe your diet in one sentence:	
What percent of your meals are home cooked?	
How many times per week do you eat at restaurants?	
Are there any foods that you do not tolerate?	

What foods did you eat often as a child?

Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Beverages:	

Submit a recent, detailed three-day dietary log (include beverages):

Breakfast:	
AM snack:	
Lunch:	
PM snack:	
Dinner:	
Eve snack:	

Breakfast:	
AM snack:	
Lunch:	
PM snack:	
Dinner:	
Eve snack:	

Breakfast:	
AM snack:	
Lunch:	
PM snack:	
Dinner:	
Eve snack:	

How would you describe your activity level:	
If you participate in a fitness program (professional or self-guided), describe your activities, sessions per week, minutes per sessions, and level of exertion:	

Do you sleep well?	
On average, what time do you go to bed, and what time do you rise?	
Do you wake in the middle of the night? At what times?	
How many times per night do you wake up to urinate?	
Do you feel well rested upon waking in the morning?	
Do you regularly experience daytime sleepiness?	
Has your partner noted that you snore loudly or stop breathing while asleep?	

ALLERGIES

Medication:	
Food:	
Environmental:	

MEDICATIONS

List all names and doses:

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

VITAMINS & SUPPLEMENTS

List all names and doses:

1)
2)
3)
4)
5)

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms (make an X)?

x	EXAMPLE		Fatigue
	Unexpected weight gain or loss		Abdominal pains
	Fevers		Chest pain
	Rashes		Palpitations (fast heart beat)
	Visual disturbance		Shortness of breath
	Frequent nasal or sinus congestion		Cough
	Hearing loss		Abnormal vaginal bleeding
	Dizziness		Loss of libido
	Headaches		Erectile dysfunction
	Loss of consciousness		Leg swelling
	Loss of sensation		Back pain
	Weakness in the extremities		Neck pain
	Bowel or bladder incontinence		Joint pains
	Urinary complaints		Muscle pains
	Nausea or vomiting		Depression
	Heartburn		Anxiety
	Loss of Appetite		Constipation
	Diarrhea		Rectal bleeding

What are your main health concerns?

By making a Lifestyle Medicine appointment at Greenville Family Medicine, what do you hope to achieve? What are your goals?