Foley Family Practice
HEIDI J. FOLEY, MD

78 Brickyard Road
Suite 2
Athol, MA 01331
Tel: (978) 249-7300
Fax: (978) 249-5785

Patient Personal Health History (pg 1)

Please initial the bottom of each page and sign and date the last page.
Confidential Record: Information contained will not be released unless you authorize us to do so.

Name: _____ _____ _____
Last First MI

Date of Birth: ____/ ____/ _____

Current Medical Problems:

Please indicate any current known medical problems you have:

Problem	Acute or Chronic	Onset date	Notes

Surgical History:

Please indicate any surgeries that you have had with the approximate dates:

Surgery	Date	Notes

Patient Personal Health History (pg 2)

Medications:
Please list the medications you are currently prescribed and any over the counter medications you take:

*****Please be sure to bring your medications with you to your 1st appointment*****

*****Please Note: Narcotic Medication Prescriptions will NOT be issued on your 1st visit. They will only be issued on future visits provided ALL requirements of this office are complied with and adhered to regarding Narcotic Medications.*****

Prescription Medications Over-the-counter Drugs Herbal Preparations	Dosage	Start Date	Stop Date	Stop Reason	Notes

Vaccines:
Please complete the request for medical records form so we can obtain your vaccination record from you previous physician.

Allergies:
Please list any allergies you have:

Drug / Allergen	Reaction	Onset Date	Notes

Patient Personal Health History (pg 3)

Past Medical History:

Problem	Yes	No	Dates / Notes
Anxiety Disorder			
Arthritis			
Asthma			
Bipolar			
COPD			
Cancer			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulitis			
Fibromyalgia			
GERD/Reflux			
Gout			
Heart Problems			
High Cholesterol			
Hypertension			
Hyperthyroidism			
Hypothyroidism			
IBS			
Kidney Disease			
Kidney Stones			
Liver Disease			
Osteoporosis			

Problem	Yes	No	Date / Notes
Colon Polyps			
Concussion			
Congestive Heart Failure			
Dentures			upper lower full
Erectile Dysfunction			
Fractures			
Glasses/Contacts			
Glaucoma			
Hearing Aids			
Heart Murmur			
Hospitalizations			
Last Breast Exam			
Last Colonoscopy			
Last Depression Screening			
Last Dexa Scan			
Last EGD			
Last Mammogram			
Last PAP			
Last PE			
Last PSA			
Last Rectal			
Last Stool Cards			
Macular Degeneration			

Past Medical History continued on next page>>>>>>>

Patient Personal Health History (pg 4)

Past Medical History Continued:

Problem	Yes	No	Notes
Pulmonary Embolism			
Tuberculosis			
Stroke			
Tuberculosis			
Abnormal PAPs			
Benign Prostate Hypertrophy			
Cataracts			
Celiac Disease			
Chronic Sinusitis			

Problem	Yes	No	Notes
Migraines			
Myasthenia Gravis			
Multiple Sclerosis			
Myasthenia Gravis			
Other			
Seizures			
Sexually Transmitted Diseases			
Suicide Attempt			
Animal Exposure			

Any other notes:	

Social History:

Occupation:	
Education Level:	
Marital Status:	
Sexual Orientation:	☐ Heterosexual ☐ Homosexual ☐ Bisexual
Exercise Level:	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How Long?_____ How Often?_____
Diet:	☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Specific ☐ Carbohydrate How Many Fruits and Vegetables per Day?_____
General Stress Level:	☐ Low ☐ Medium ☐ High
Smoking – How Much?:	☐ No ☐ Yes How Much?_____
Has Smoked Since Age:	

Social History continued on next page>>>>>>>>>

Patient Personal Health History (pg 5)

Social History Continued:

Alcohol Intake:	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How Many per Month?_____
Caffeine Intake:	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How Many Servings per Day?_____
Chewing Tobacco:	☐ None ☐ 1/day ☐ 2-4/day ☐ 5+/day
Illicit Drugs:	
Guns Present in Home:	☐ Yes ☐ No If Yes, Are They Locked?_____
Seatbelts Used Routinely:	☐ Yes ☐ No
Sunscreen Used Routinely:	☐ Yes ☐ No
Smoke Alarm in Home:	☐ Yes ☐ No
Advanced Directive:	☐ Yes ☐ No If Yes, Please Provide Us With A Copy.
Smoking Status:	☐ Never ☐ Former ☐ Current ☐ Unknown
Mosquito Repellent Used Routinely:	☐ Yes ☐ No
Number of Children:	
Is Blood Transfusion Acceptable In Emergency?:	☐ Yes ☐ No
Live Alone or With Others:	
Sporting Activities:	List: _____
Sexually Active?:	☐ Yes ☐ No
Hand Dominance:	☐ Right ☐ Left ☐ Both
What Are Your Goals For Improving Your Health?:	
What Language Do You Prefer Us To Us.:	
Were You Born in The USA?:	☐ Yes ☐ No
Talk on the Phone When You Drive:	☐ Yes ☐ No
Fire Extinguishers in Home:	☐ Yes ☐ No
Do You Text and Drive:	☐ Yes ☐ No
CO Detectors in Home:	☐ Yes ☐ No
Do You Drive the Speed Limit:	☐ Yes ☐ No
Number of Sexual Partners In Your Lifetime:	
Do You Practice Safe Sex?:	☐ Yes ☐ No

Patient Personal Health History (pg 6)

Family Medical History:

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Unspecified
Alcohol / Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CAD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endocrine Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy / Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack(MI)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Diagnosis**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

**If you have indicated a family member with a history of cancer please indicate the type of cancer here:_____

**If you have indicated a family member with "other" or "other diagnosis" please provide more information here:_____

Patient Personal Health History (pg 7)

Past and Present Patient Providers:
Please list any past providers that you have utilized and any current providers you are seeing:

Provider Name	Provider Address	Provider Specialty	Current Provider?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Pharmacies:
Please list any pharmacies you currently utilize.
Please note the **one** default pharmacy. This will be the pharmacy that all scripts will be electronically sent.

Indicate **One** as Primary	Pharmacy Name	Pharmacy Address	Pharmacy Phone
☐			
☐			
☐			
☐			

GYN History:

Duration of Flow (Days):	
Last Menstrual Period:	☐ Unknown ☐ Approximate ☐ Definite
Frequency of Cycle (Days):	
Menses Monthly:	☐ Yes ☐ No
Flow:	☐ Light ☐ Moderate ☐ Heavy
Age at First Child:	
Age at Menarche:	
Current Birth Control Method:	☐ BCPs ☐ IUD ☐ Diaphram ☐ Tubal Ligation ☐ Partner Vasectomy ☐ Depo- Provera ☐ Condoms ☐ None
On BCPs at Conception?:	
If Postmenopausal, Age at Menopause:	
Date of Last Menstrual Period:	

Patient Personal Health History (pg 8)

Obstetric History:

Total	Full Term	Premature	Elective Abortion	Miscarriage	Ectopic	Multiple

Please list any other information you feel is pertinent to your medical care below:

_____

_____

_____

_____

_____

_____

_____ ____/____/_____

Patient Signature Date