ABQ Integrative Family Medicine

(PLEASE PRINT CLEARLY)

Name: _____

Date of Birth: _____ Today's Date: _____

MEDICAL HISTORY

Please list any current medical conditions that you have and specialists if applicable
(For example: asthma, diabetes, epilepsy...)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Females- Please Complete

Menstrual Flow:
☐ Regular ☐ Irregular
☐ Pain/cramps ☐ Menopausal
☐ Hysterectomy
Days of flow _____
Length of cycle _____
First day of last period: _____

☐ Pregnant
☐ Planning Pregnancy
Pregnancies _____
Abortions _____
Miscarriages _____
Live Births _____

☐ Children—Years of birth/names:
_____
_____
_____
_____

☐ Birth Control Method
(If pill, provide name):
_____

Date of last PAP: _____
☐ History of abnormal?
Date of abnormal: _____

Date of last Mammogram:
_____
☐ History of abnormal?
Date of abnormal: _____

Date of last DEXA: _____
☐ History of abnormal?
Date of abnormal: _____

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SOCIAL HISTORY/HABITS

☐ Alcohol

Types: _____ *Amount per week:* _____

☐ Caffeine

Types: _____ *Amount per week:* _____

☐ Nicotine

☐ Cigarettes- *Packs daily:* _____ *How Long:* _____

☐ Chewing Tobacco ☐ Pipe ☐ Cigars-

Frequency: _____ *Pouches per week:* _____ *Frequency:* _____

☐ Vape *(please bring packaging to appointment)-*

Mg/mL: _____ *Cartridges per week:* _____

☐ Cannabis: edibles flower wax vape *(circle all that apply)*

Types: _____ *Frequency:* _____

☐ Other recreational drugs-

Types: _____ *Frequency:* _____

_____ _____

☐ Diet *(including dietary restrictions)*

Type: _____

_____

_____

☐ Exercise

Routine: _____

Frequency: _____

☐ Occupation/Prior Occupations/Volunteering

_____

_____

Who lives at home? _____

_____

Comments: _____

_____

_____

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FAMILY HISTORY

MOTHER:
Serious Medical Conditions

FATHER:
Serious Medical Conditions-

D.O.B or if deceased list cause and age at death-

CHILDREN:
Serious Medical Conditions

SIBLINGS:
Serious Medical Conditions-

D.O.B or if deceased list cause and age at death-

GENERAL FAMILY HISTORY OF ISSUES:

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SURGICAL HISTORY

Surgery	Date
☐ Colonoscopy	
☐ EGD (Upper Endoscopy)	
OTHER	
Comments: (Any repeat surgeries?) _____	

VACCINES

Vaccine	Date
☐ Tdap ☐ Td	
☐ Pneumovax-13	
☐ Pneumovax-23	
☐ Shingrix-1	
☐ Shingrix-2	
☐ Flu shot- most recent	
OTHER	

Current Concerns to address: _____

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