Melissa Selke, M.D., P.C.
Family Medicine
A place where patients become family

Patient History Form

Patient Name: DOB:
Provider: Date of Visit:

Place of birth:

Please answer the questions below. Your responses will remain confidential. You may omit any questions with which you may be uncomfortable.

GENERAL INFORMATION

Please indicate medical conditions you have had:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ Cancer (type: ___________)
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ GERD
- ☐ Obesity
- ☐ Anemia
- ☐ Migraines
- ☐ Anxiety
- ☐ Depression

Additional Medical Conditions

____
____
____

Please indicate surgical procedures you may have had:

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Gallbladder Surgery
- ☐ Hysterectomy (Full or Partial)
- ☐ Cesarean Section
- ☐ Back Surgery

Additional Surgeries (Indicate Procedure and date)

____
____
____

Medical Allergies (Describe Reaction. Include allergies to iodine or contrast dye.)

Medication	Reaction

Additional Allergies (Includes seasonal, food, etc.)

Allergen	Reaction

Medications and Dosages (Include over-the-counter supplements and remedies.)

Medication	Dose	Frequency

Diagnostic Testing (Include the most recent date and location where they were received.)

Test	Date	Location
☐ PAP/Pelvic Exam (female)		
☐ Mammogram (female)		
☐ Breast Exam – Physician (female)		
☐ Prostate Specific Antigen (PSA) Test (male)		
☐ Prostate Exam – Physician (male)		
☐ Colonoscopy		
☐ Bone Density		
☐ Hepatitis C Screening Bloodwork (if born between 1945-65)		

Diagnostic Vaccines (Include the most recent date and location where they were received.)

Vaccine	Date	Location
☐ Flu Shot		
☐ Tetanus Booster		
☐ Pertussis Booster (“Whooping Cough”)		
☐ Shingles Vaccine (adults over 50)		
☐ HPV Vaccine (women under 45)		
☐ Pneumonia Vaccine (adults over 65)		

SPECIALISTS

Please indicate the specialists you have seen in the past and/or are currently seeing:

Specialist Type	Physician's Name	Location	Phone #	Current	Past
☐ Cardiologist					
☐ Endocrinologist					
☐ Gastroenterologist					
☐ Gynecologist (GYN)					
☐ Ophthalmologist					
☐ Pulmonologist					
☐ Rheumatologist					
☐ Urologist					
☐ Other _______________					

PHARMACY

Please include address and phone number (if known).

Local Pharmacy ____

Mail Order Pharmacy ____

FAMILY MEDICAL HISTORY

Check all that apply. Please include current age or age at death.

Father

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other __________________

Mother

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other __________________

Sibling (brother/sister)

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Prostate Cancer (male)
- ☐ Breast Cancer (female)
- ☐ Ovarian Cancer (female)
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other __________________

Sibling (brother/sister)

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Prostate Cancer (male)
- ☐ Breast Cancer (female)
- ☐ Ovarian Cancer (female)
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other ________________

Grandmother (Indicate Maternal or Paternal)

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other ________________

Grandfather (Indicate Maternal or Paternal)

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other ________________

Maternal Uncle/Aunt (Indicate Maternal or Paternal)

Alive? Y/N Age:

- ☐ Colon Cancer
- ☐ Prostate Cancer (male)
- ☐ Breast Cancer (female)
- ☐ Ovarian Cancer (female)
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other ______________

Additional Family Member(s) ____________________

Alive? Y/N Age:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Colon Cancer
- ☐ Prostate Cancer (male)
- ☐ Breast Cancer (female)
- ☐ Ovarian Cancer (female)
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Other ________________

SOCIAL HISTORY

1. Do you drink coffee, tea, or soda? Yes ☐ No ☐
   If yes, amount per day ____________________

2. Do you regularly use tobacco products? Yes ☐ No ☐
   If yes, what kind?
   - ☐ Cigarettes
   - ☐ Cigar
   - ☐ Pipe
   - ☐ Vape
   - ☐ Hookah
   - ☐ Other ________

   If yes, how often do you use tobacco products? _____________________

3. Have you ever used tobacco products? Yes ☐ No ☐
   If yes, when did you start? ____________ When did you stop? _____________
   If yes, how often did you use tobacco products? _____________________

4. Do you drink alcohol? Yes ☐ No ☐
   If yes, how often are you drinking? Be specific about *what* you are drinking, i.e., beer (12 oz), wine (5 oz), or liquor (1 ½ oz).
   _________________ per day. _________________ per month.
   _________________ per week. _________________ per year.

5. Do you regularly smoke marijuana? Yes ☐ No ☐
   If yes, how often do you smoke? ___________________

6. Have you ever smoked marijuana? Yes ☐ No ☐
   If yes, when did you start? ____________ When did you stop? _____________
   If yes, how often did you smoke marijuana? ____________________

7. Do you regularly use other illicit drugs? Yes ☐ No ☐
   If yes, what drugs? ________________ How often do you use? __________

8. Have you ever used other illicit drugs? Yes ☐ No ☐
   If yes, what drugs? ________________ How often did you use? __________
   If yes, when did you start? ____________ When did you stop? _____________

9. Please indicate sexual orientation:
   ☐ Heterosexual ☐ Bisexual ☐ Other _____________
   ☐ Homosexual ☐ Prefer not to say

10. What is your marital status?
    ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

11. Do you have children? Yes ☐ No ☐
    If yes, please list their age(s) ___________________

12. What is your occupation? ___________________

13. Please indicate education level: ____________________

14. Do you exercise regularly? Yes ☐ No ☐
    If yes, how much exercise do you get per week? _______________________________________
    What type of exercise? _______________________________________

15. Do you currently follow a specific diet? Yes ☐ No ☐
    If yes, please indicate type: _______________________________________

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