STECK MEDICAL GROUP
PAST, FAMILY, AND SOCIAL HISTORY

Patient Name: ______________________ Age: ________ Date: ________

MEDICINES TAKEN REGULARLY

MEDICINES TAKEN REGULARLY	Reason

PERSONAL PAST HISTORY

Have you ever had?			Year
Measles	yes	no	
Mumps	yes	no	
Whooping cough	yes	no	
Polio	yes	no	
Diphtheria	yes	no	
Meningitis	yes	no	
Valley fever	yes	no	
Malaria	yes	no	
Hives	yes	no	
Cancer	yes	no	
Venereal Disease	yes	no	
Arthritis	yes	no	
Rheum. Fever	yes	no	
Heart Failure	yes	no	
Blood transfusions	yes	no	
Hepatitis	yes	no	
Kidney disease	yes	no	
Hay fever	yes	no	
Glaucoma	yes	no	
Thyroid Disease	yes	no	
Other:			

Operations			Year
Tonsil	yes	no	
Appendix	yes	no	
Gallbladder	yes	no	
Stomach	yes	no	
Breast	yes	no	
Uterus, ovary	yes	no	
Prostate	yes	no	
Hernia	yes	no	
Thyroid	yes	no	
Varicose veins	yes	no	
Hemorrhoids	yes	no	
Hip	yes	no	
Knee	yes	no	
Other:			

INJURIES

INJURIES			Year
Head	yes	no	
Chest	yes	no	
Abdomen	yes	no	
Broken bones	yes	no	
Back	yes	no	
Other:			

ALLERGIES

ALLERGIES			Year
Tetanus	yes	no	
Penicillin	yes	no	
Sulfa	yes	no	
Other			

IMMUNIZATIONS

IMMUNIZATIONS			Year
Influenza	yes	no	
Pneumococcal	yes	no	
Tetanus	yes	no	
Hepatitis B	yes	no	

OB/GYN

OB/GYN		Year
Pregnancies	# ____	
Miscarriages	# ____	
Abortions	# ____	
First Period:		
Last Period:		

SOCIAL HISTORY #1

Birth Place: Birth Date:

Religion: Marital Status:

Occupations:

Do you have a "**Living Will**?" yes no

PRACTITIONER'S NOTES

FAMILY HISTORY

Have **you** or any **blood** relative had any of the following:

			Relationship
Anemia	yes	no	
Bleeding tendency	yes	no	
Repeated infections	yes	no	
Heart Attack/Angina	yes	no	
Chronic lung disease	yes	no	
Tuberculosis	yes	no	
High Blood Pressure	yes	no	
Asthma	yes	no	
Severe allergies	yes	no	
Mental or emotional illness	yes	no	
Seizures	yes	no	
Migraine headaches	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Obesity	yes	no	
Ulcer	yes	no	
Chronic diarrhea	yes	no	
Cancer/Leukemia	yes	no	
Alcohol or Drug Problem	yes	no	
Family violence/abuse	yes	no	

	Present age or age at death	If living, health good, fair or poor. If deceased, cause of death.
Father		
Mother		
Brothers or Sisters		
Spouse		
Children		

SOCIAL HISTORY #2

In an average **week** I exercise or work vigorously: hrs.

My compliance with a healthy diet:
poor fair good excellent

My religious faith is:
none average important vital

My sexual orientation is:
heterosexual homosexual ("gay") other

AVERAGE PER DAY

Alcohol – type ________

Tobacco – type ________

Tea or coffee ________

*Please complete **both** sides*

CURRENTLY or in the last six months have you experienced:
(Circle 'yes' or 'no' — if in doubt, leave blank)

GENERAL:		
Fatigue, tiring easily	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
EYES:		
Trouble seeing	yes	no
Eye pain	yes	no
Inflamed eyes	yes	no
Wear glasses	yes	no
EARS, NOSE & THROAT:		
Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge from an ear	yes	no
Loss of smell	yes	no
Nasal obstruction	yes	no
Excess nasal discharge	yes	no
Nose bleeds	yes	no
Sore gums or tongue	yes	no
Dental problems	yes	no
Post nasal drainage	yes	no
Hoarseness	yes	no
NECK:		
Stiffness, swelling, or pain	yes	no
CARDIAC SYSTEM:		
Chest pain	yes	no
Swelling of ankles	yes	no
Bluish fingers or lips	yes	no
High blood pressure	yes	no
Palpitations	yes	no
Vein trouble	yes	no
RESPIRATORY SYSTEM:		
Shortness of breath	yes	no
Cough, persisting	yes	no
Bloody sputum	yes	no
Wheezing	yes	no
DIGESTIVE SYSTEM:		
Change in appetite	yes	no
Difficulty swallowing	yes	no
Heartburn	yes	no
Abdominal pain	yes	no
Abdominal enlargement	yes	no
Belching or excess gas	yes	no
Nausea or vomiting	yes	no
Vomiting of blood	yes	no
Rectal bleeding	yes	no
Dark stools	yes	no
Constipation	yes	no
Diarrhea	yes	no
Hemorrhoids	yes	no
Any food intolerance	yes	no
Need for laxatives	yes	no

Which? ______________________________

GENITOURINARY SYSTEM:		
Unable to hold urine	yes	no
Pain or burning on urination	yes	no
Nighttime urination	yes	no
Blood in urine	yes	no
Satisfied with sexual activity	yes	no
Vaginal discharge or malodor	yes	no
Pain with intercourse	yes	no
LOCOMOTOR:		
Muscle cramps	yes	no
Muscle weakness	yes	no
Joint pain, swelling, or stiffness	yes	no
SKIN:		
Rash	yes	no
Hives or itching	yes	no
Change in hair or nails	yes	no
Dry skin	yes	no
Easy bruising	yes	no
Change in a mole	yes	no
Non healing sore	yes	no
BREASTS/CHEST:		
Lumps	yes	no
Pain	yes	no
Discharge	yes	no
NERVOUS/MENTAL SYSTEM:		
Headaches	yes	no
Dizziness/loss of balance	yes	no
Fainting	yes	no
Seizures or epilepsy	yes	no
Memory loss	yes	no
Change in sensation	yes	no
Poor coordination	yes	no
Weakness or paralysis	yes	no
Nervousness, anxiety	yes	no
Sleeplessness	yes	no
Depression, grief, or sadness	yes	no
Family problems	yes	no
Occupational concerns	yes	no
Hard to find pleasure	yes	no
ENDOCRINE:		
Excess thirst	yes	no
Menstrual problems	yes	no
Intolerance to heat or cold	yes	no
Hot flashes	yes	no
HEMATOLOGIC & IMMUNOLOGIC:		
Lymph node swelling or pain	yes	no
Allergy symptoms	yes	no
Risk of HIV (AIDS)	yes	no

Any other current concerns:

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*Please complete **both** sides*