380 Plaza Drive, Suite D
Columbus, IN 47201

RAU FAMILY MEDICINE

Date: _____

PATIENT SOCIAL HISTORY

Parents: Have you signed our minor consent form for your children? ❑ yes ❑ no Initials _____

Name: _____ **DOB:** _____ **Soc. Sec. #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse (parent) name: _____ **Employment:** _____

In case of emergency contact: _____ Phone #: _____

Birth History: ❑ vaginal delivery ❑ c-section Complications: _____

Where were you born? _____ Obstetrician: _____ Pediatrician: _____

Marital Status:

❑ Single; Significant other? ❑ yes ❑ no; If yes: Name of significant other: _____

❑ Married #1 Date_____; #2 Date_____; #3 Date_____.

❑ Divorced #1 Date_____; #2 Date_____; #3 Date_____.

❑ Widowed #1 Date_____; #2 Date_____; #3 Date_____.

Religion/Church Affiliations: _____

Education: Did you attend pre-school?: ❑ yes ❑ no What is the highest level of education you have completed?

❑ some high school ❑ high school graduate ❑ college or technical degree ❑ post graduate college

Last School attended _____

Military: _____ **Stationed:** _____

• Please list employment in chronological order starting with your current/most recent employment.

Note: For those under 18 yrs. include parents occupations. Designate mother = M, father = F.

Employment	Start	End	Job Description	Health / Safety Risks
1.				
2.				
3.				

Insurance: Primary; _____ **Secondary;** _____

Deductible: _____ **Co-insurance / Co-payment:** _____

Network Limitation: ❑ yes ❑ no **Point of Service Agreement:** ❑ yes ❑ no

Community / School Activities: _____

_____

Any recent situational stressors or major life changes?: _____

_____

Children Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1.					
2.					
3.					
4.					
5.					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
Functional Status: Dependent = D, Independent = I.

Sibling Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1.					
2.					
3.					
4.					
5.					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
Functional Status: Dependent = D, Independent = I.

Parents: Are they?: ❑ never married ❑ married Date:_____ ❑ divorced Date:_____ ❑ remarried / father Date:_____ ❑ remarried / mother Date:_____

Are they ❑ dependent or ❑ independent? If dependent, why? _____

Do you have grandparents living? ❑yes ❑ no

If yes, are they ❑ dependent or ❑ independent? If dependent, why? _____

Do you have grandchildren? ❑ yes ❑ no

If yes, are they ❑ dependent or ❑ independent? If dependent, why? _____

Are there others with whom you relate closely and share personal experiences? ❑ no ❑ yes Who: _____

If yes, are they ❑ dependent or ❑ independent? If dependent, why? _____

Secondary Caregivers for Children, Parents or Spouse:

Name	Location	Sex	Type*	For Whom?
1.				
2.				
3.				

Type of caregiver: Baby-sitter = B; Day Care = D; Home Health Aid = A; Nurse = N.

Have you made a living will? ❑ yes ❑ no **Have you assigned a Health Care Representative?** ❑ yes ❑ no

NAME:

INSTRUCTIONS: PUT ✓ IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

BIOLOGIC AND PSYCHOLOGIC FAMILY HISTORY

M - MATERNAL P - PATERNAL GM - GRANDMOTHER GF - GRANDFATHER	MOTH	FATH	M GM	M GF	P GM	P GF	BROTHER 1	BROTHER 2	BROTHER 3	BROTHER 4	SISTER 1	SISTER 2	SISTER 3	SISTER 4	SPOUSE	CHILDREN 1	CHILDREN 2	CHILDREN 3	CHILDREN 4
AGE (IF LIVING)																			
HEALTH (G) GOOD (B) BAD																			
CANCER																			
TUBERCULOSIS																			
DIABETES																			
HEART TROUBLE																			
HIGH BLOOD PRESSURE																			
STROKE																			
EPILEPSY																			
ALCOHOL DEPENDENCE																			
NERVOUS BREAKDOWN																			
ASTHMA, HIVES, HAYFEVER																			
BLOOD DISEASE																			
OTHER																			
AGE (AT DEATH)																			
CAUSE OF DEATH																			
DATE OF DEATH (MO/YR)																			

PERSONAL HISTORY

HAVE YOU EVER HAD . . .	DATE	NO	YES	HAVE YOU EVER HAD . . .	DATE	NO	YES	HAVE YOU EVER HAD . . .	DATE	NO	YES
☐ SCARLET FEVER ☐ SCARLATINA				☐ GONORRHEA ☐ SYPHILIS ☐ HERPES				ANY ☐ BROKEN ☐ CRACKED BONES			
☐ CHLAMYDIA ☐ GENITAL WARTS				ANEMIA				RECURRENT DISLOCATIONS			
CHICKEN POX ☐ VACCINE GIVEN ☐				JAUNDICE				☐ CONCUSSION ☐ HEAD INJURY			
PNEUMONIA				EPILEPSY				EVER BEEN KNOCKED UNCONSCIOUS			
PLEURISY				MIGRAINE HEADACHES				☐ FOOD ☐ CHEMICAL ☐ DRUG POISON.			
MONO				URINARY TRACT INFECTIONS				EXPLAIN (BONES, HEAD, POISONING)			
☐ RHEUMATIC FEVER ☐ HEART DISEASE				DIABETES							
REYES SYNDROME				CANCER							
☐ ARTHRITIS ☐ RHEUMATISM				☐ HIGH ☐ LOW BLOOD PRESSURE				ANY OTHER DISEASE			
ANY ☐ BONE ☐ JOINT DISEASE				SIGNIFICANT BEHAVIOR PROBLEM				EXPLAIN			
☐ NEURITIS ☐ NEURALGIA				☐ HAY FEVER ☐ ASTHMA ☐ ALLERGIES							
☐ BURSITIS ☐ SCIATICA ☐ LUMBAGO				☐ HIVES ☐ ECZEMA							
☐ POLIO ☐ MENINGITIS				FREQUENT ☐ COLDS ☐ SORE THROAT				WEIGHT: NOW ONE YR. AGO			
STROKE OR CEREBRAL PALSY				FREQUENT ☐ INFECTIONS ☐ BOILS				MAXIMUM WHEN			

SURGERYS & HOSPITALIZATIONS

REMOVED . . .	SURGEON	DATE	NO	YES	REMOVED . . .	SURGEON	DATE	NO	YES	HAVE YOU . . .	SURGEON	DATE	NO	YES
☐ TONSILS ☐ ADENOIDS					CIRCUMCISION					HAD HERNIA REPAIRED?				
APPENDIX					MOLE REMOVAL					HAD ANY OTHER OPERATIONS?				
GALL BLADDER					TRANSFUSION . . .					BEEN HOSPITALIZED FOR ANY ILLNESS?				
☐ UTERUS ☐ OVARY ☐ OVARIES					☐ BLOOD ☐ PLASMA					PLEASE EXPLAIN BELOW NOTING DATES, SURGEONS, PHYSICIANS, & HOSPITALS				

DIAGNOSTIC STUDIES

EVER HAD STUDIES OF . . .	NO	YES	DATE	DISEASE PRESENT
CHEST ☐ XRAY ☐ CAT SCAN				
STOMACH ☐ XRAY ☐ ENDOSCOPY				
COLON ☐ XRAY ☐ COLONOSCOPY				
GALL BLADDER ☐ XRAY ☐ ULTRASOUND				
EXTREMITIES ☐ XRAY ☐ MRI				
BACK ☐ XRAY ☐ CAT SCAN ☐ MRI				
SIGMOIDOSCOPY				
☐ EKG ☐ ECHO ☐ TREADMILL				
OTHER				

ALLERGIES

ARE YOU ALLERGIC TO . . .	DATE	NO	YES	ARE YOU ALLERGIC TO . . .	DATE	NO	YES	ARE YOU ALLERGIC TO . . .	DATE	NO	YES
☐ PENICILLIN ☐ SULFA DRUGS				ANY OTHER DRUGS				ANY FOODS			
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE				EXPLAIN				EXPLAIN			
☐ MYCINS ☐ OTHER ANTIBIOTICS											
☐ TETANUS ☐ ANTITOXIN ☐ SERUMS				ADHESIVE TAPE				☐ NAIL POLISH ☐ OTHER COSMETICS			

BIOLOGIC REVIEW OF SYSTEMS

DO YOU HAVE OR HAVE YOU EVER HAD...	DATE	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD...	DATE	NO	YES
ANY ❑ EYE DISEASE ❑ EYE INJURY ❑ IMPAIRED SIGHT ❑ GLASSES ❑ CONTACTS				KIDNEY ❑ DISEASE ❑ STONES			
ANY ❑ EAR DISEASE ❑ EAR INJURY ❑ IMPAIRED HEARING ❑ BRACES				BLADDER DISEASE ❑ VAGINAL TROUBLE ❑ PENILE TROUBLE ❑			
ANY TROUBLE WITH ❑ NOSE ❑ SINUSES ❑ MOUTH ❑ THROAT				BLOOD IN URINE			
❑ FAINTING SPELLS ❑ SPASMS				❑ ALBUMIN ❑ SUGAR ❑ PUS ❑ ETC. IN URINE			
❑ CONVULSIONS ❑ PARALYSIS ❑ MOVEMENT PROBLEMS				DIFFICULTY IN URINATION			
❑ BONE PAIN ❑ JOINT PAIN ❑ WALKING DIFFICULTY				NARROWED URINARY STREAM			
❑ DIZZINESS ❑ VERTIGO (ROOM SPINNING)				ABNORMAL THIRST ❑ ABNORMAL APPETITE ❑			
HEADACHES: FREQUENT ❑ SEVERE ❑				❑ UTERINE TROUBLE ❑ OVARIAN TROUBLE			
ENLARGED GLANDS ❑ TUMORS ❑				❑ PROSTATE TROUBLE ❑ TESTICLE TROUBLE			
THYROID: ❑ OVERACTIVE ❑ UNDERACTIVE ❑ ENLARGED				❑ STOMACH TROUBLE ❑ ULCER			
ENLARGED GOITER OR THYROID				INDIGESTION ❑ HEARTBURN ❑ TROUBLE SWALLOWING ❑			
❑ SKIN DISEASE ❑ CHANGING MOLES				❑ GAS ❑ BELCHING			
COUGH: ❑ FREQUENT ❑ PERSISTENT ❑ THROAT CLEARING				❑ LIVER DISEASE ❑ GALL BLADDER DISEASE			
❑ CHEST PAIN ❑ AT REST ❑ EXERTION ❑ AT NIGHT				❑ COLITIS ❑ OTHER BOWEL DISEASE			
SPITTING UP BLOOD ❑ NOSE BLEEDS ❑				❑ HEMORRHOIDS ❑ RECTAL BLEEDING ❑ ANAL ITCHING			
NIGHT SWEATS ❑ HAND & FEET SWEATING ❑ ARMPIT SWEATING ❑				BLACK TARRY STOOLS			
SHORTNESS OF BREATH ❑ EXERTION ❑ AT NIGHT ❑ SNORING				❑ CONSTIPATION ❑ DIARRHEA			
❑ PALPITATION ❑ FLUTTERING HEART ❑ WHEEZING				❑ PARASITES ❑ WORMS			
SWELLING OF: ❑ HANDS ❑ FEET ❑ ANKLES				❑ ANY CHANGE IN APPETITE ❑ EATING HABITS			
❑ BIRTH MARKS ❑ BIRTH IRREGULARITIES				❑ ANY CHANGE IN BOWEL ACTION ❑ STOOLS			
EXTREME ❑ TIREDNESS ❑ WEAKNESS				WEIGHT CHANGE IN LAST 3 MONTHS? NO ❑ YES ❑ HOW MUCH?			

PSYCHOLOGICAL & EMOTIONAL REVIEW OF SYSTEMS

ARE YOU OFTEN	DATES	NO	YES		DATES	NO	YES
DEPRESSED				HAVE YOU EVER BEEN INVOLVED IN COUNSELING			
ANXIOUS				OTHER TREATMENTS (IE. BIOFEEDBACK)			
IRRITABLE				IS CONCENTRATION DIFFICULT ❑ IS THINKING DIFFICULT ❑			
JUMPY				HAVE YOU EVER HAD SUICIDE THOUGHTS OR HOMICIDE THOUGHTS			
JITTERY				HAVE YOU EVER HAD A SUICIDE PLAN OR HOMICIDE PLAN			

GIRLS ONLY

MENSTRUAL HISTORY...		NO	YES
AGE AT ONSET ANY RECENT CHANGE IN CYCLE	HAVE YOU OR DO YOU USE NON-SURGICAL CONTRACEPTION (PILL, IU, ETC.)		
DATE OF LAST PERIOD	ARE YOU REGULAR: ❑ HEAVY ❑ MEDIUM ❑ LIGHT		
USUAL DURATION OF PERIOD DAYS	DO YOU HAVE ❑ TENSION ❑ DEPRESSION BEFORE PERIOD		
CYCLE (START TO START) DAYS	DO YOU HAVE ❑ CRAMPS ❑ PAIN WITH PERIOD ❑ HOT FLASHES		

PREGNANCIES...	OBSTETRICIAN	DATES	NO	YES		OBSTETRICIAN	DATES	NO	YES
CHILDREN BORN ALIVE (HOW MANY)					STILL BORN (HOW MANY)				
CESAREAN SECTIONS (HOW MANY)					MISCARRIAGES / ABORTIONS (HOW MANY)				
PREMATURES (HOW MANY)					ANY COMPLICATIONS				

IMMUNIZATION AND INFECTION RISK

HAVE YOU HAD...	DATE	NO	YES	HAVE YOU HAD...		NO	YES
POSITIVE TB SKIN TEST				PRIMARY CHILDHOOD IMMUNIZATION (DPT, POLO, HIB, MMR)			
TETANUS BOOSTER (NOT ANTITOXIN) ❑ DATE _____ MMR BOOSTER ❑ DATE _____				PNEUMONIA SHOT ❑ DATE_____ HEPTOVAX ❑ DATE _____			

LIFESTYLE AND MEDICATION

DO YOU, HAVE YOU, OR ARE YOU...	NO	YES	DO YOU USE...	NEVER	OCC.	FREQ.	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS ❑ SUPPLEMENTS ❑				
AWAKEN RESTED			SEDATIVES OR SLEEPING PILLS				
SLEEP WELL AVERAGE HOURS SLEEP (PER NIGHT)			ANTI DEPRESSANTS				
EAT A WELL-BALANCED DIET			MILK				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRINS, ETC.				
CHOOSE TO BE SEXUALLY ACTIVE			CONDOMS				
ACHIEVE SUCCESSFULLY IN SCHOOL (HOURS PER DAY)			ALCOHOLIC BEVERAGE				
WORK (HOURS PER DAY) ❑ INDOORS ❑ OUTDOORS			❑ COFFEE ❑ TEA (CUPS PER DAY)				
WATCH TELEVISION (HOURS PER DAY)			SOFT DRINKS				
READ (HOURS PER DAY)			❑ TOBACCO: CIGARETTES (PKS / DAY)				
EVER BEEN TREATED FOR ALCOHOL DEPENDENCE			❑ CIGARS ❑ PIPE ❑ CHEWING TOBACCO				
EVER BEEN TREATED FOR DRUG DEPENDENCE			❑ SNUFF ❑ CHOCOLATE				
PARTICIPATE IN SPORTS OR HAVE HOBBIES (HOURS PER WEEK)			APPETITE DEPRESSANTS ❑ HERBS ❑				
BLEND EASILY WITH YOUR PEER GROUP			THYROID MEDICATION: ❑ NO ❑ YES, IN PAST ❑ NONE NOW ❑ NOW ON				
❑ A VEGETARIAN ❑ RIGHT HANDED ❑ LEFT HANDED ❑ BOTH			OTHER MEDICATION:				