



Oyster Point Family Practice

Name: _____

SSN: _____ Birth Date: _____

Insurance Co: _____

Allergies

Drug	Reaction	Drug	Reaction	Drug	Reaction

Medical Problem List

Surgical Problem List

Medical Problem	Year	Surgery	Year

Medication List

Medication	Dose	Frequency

Doctors (previously seen)	Specialist	Other

Family History

☐ Adopted

Relation	No.	Birth Year(s)	Death Age	Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				
Other				

Social History

Occupation: _____	Ret Yr: _____	IV Street Drugs? ☐ CURRENT ☐ PAST ☐ NO
Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		Recreational Drugs? ☐ CURRENT ☐ PAST ☐ NO
Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other: _____		Alcoholism? ☐ CURRENT ☐ PAST ☐ NO
Sexual Lifestyle: ☐ Traditional ☐ Alternative Sexually Active: YES NO		
Tobacco ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew _____ per day wk mo		
Alcohol ☐ Beer ☐ Wine ☐ Mixed ☐ Liquor _____ per day wk mo		

Risk Assessment Questions

Please answer the following questions so we may be able to determine from your medical history and your family history if you are at high risk for the following diseases.

Female Cancer (cervical , vaginal, breast) * **Circle One**

Were you sexually active before the age of 16 years ? YES NO

Have you had more than five sexual partners in your life ? YES NO

Have you ever had a sexually transmitted disease ? YES NO

Have you had fewer than 3 negative pap smears in the past 3 years? YES NO

Did your mother take DES(diethylstilbestrol) during pregnancy ? YES NO

Do you have a history of breast cancer ? YES NO

What is your current age ? _____

What was your age at the time of your first menstrual period ? _____

What was your age at the first live birth of a child ? _____

How many first degree relatives (mother, sisters, daughters) have had breast cancer ? _____

Have you ever had a breast biopsy ? YES NO

What is your race ? White Black Asian Other (circle one)

Heart Disease

Have you had a first degree relative (father ,brothers) that has had a heart attack before the age of 45 ? YES NO

Have you had a first degree relative (mother, sisters) that has had a heart attack before the age of 55 ? YES NO

Are you overweight ? YES NO What is your current age ? _____

Do you smoke ? YES NO Do you have diabetes ? YES NO

Do you have hypertension (high blood pressure) ? YES NO

* These questions are required by Medicare in order to determine if the pelvic, pap, and breast exams will be covered every year or every 3 years.