

Patient Name: _____ Date: _____

Reason for today's visit: _____

ALLERGIES: List any allergies to medications/substances and their reactions.

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Over the last 6 months, have you had:

_____ NO _____ YES An Operation	_____ NO _____ YES Change of address
_____ NO _____ YES Inpatient Hospitalization	_____ NO _____ YES Quit work, retired, change job or duties
_____ NO _____ YES A new illness	_____ NO _____ YES Change of primary care or other doctor
_____ NO _____ YES An important new symptom	(Circle): Single, Married, Divorced, Widow

(Please explain any "YES" answers below, or write anything else you may think the doctor should know)

PAST MEDICAL HISTORY: List problems you have had and the year.

1
2
3
4
5

PAST SURGICAL HISTORY: List surgeries you have had and the year.

1
2
3
4
5

Hospitalizations: Please list Hospital and Date

1
2
3
4

MEDICATIONS: List medications you are currently taking.

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Fill in health information about your family: (stroke, heart disease, cancer, asthma, COPD, HTN, sickle cell, diabetes, asbestosis, blood clots, allergies, immune disorders.

	Age	Sate of Health	Age at Death	Cause of Death/Disease
Father				
Mother				
Brothers				
Sisters				
Children				

List any illnesses that run in your family:

1	6
2	7
3	8
4	9
5	10

PREGNANCY HISTORY:

Year of Birth	Sex of Birth	Delivery Type	Complications if any

SOCIAL HISTORY: Describe use

Caffeine	
Tobacco	
Alcohol	
Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Physician Signature:

Date