Patient Name:_____Date:_____

Reason for today's visit:_____

_____

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

Over the last 6 months, have you had:

_____NO _____YES An Operation

_____NO _____YES Inpatient Hospitalization

_____NO _____YES A new illness

_____NO _____YES An important new sympton

_____NO _____YES Change of address

_____NO _____YES Quit work, retired, change job or duties

_____NO _____YES Change of primary care or other doctor

(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**