PATIENT HISTORY

NAME: LAST	FIRST	MIDDLE	DOB	AGE	SEX M F
EMERGENCY CONTACT PERSON			RELATIONSHIP		HOME PHONE: ( )
PHARMACY PHONE #:	HEIGHT	WEIGHT	OCCUPATION		

CURRENT MEDICAL PROBLEMS

IF YOU ARE BEING TREATED FOR ANY OTHER ILLNESSES OR MEDICAL PROBLEMS BY ANOTHER PHYSICIAN, PLEASE DESCRIBE THE PROBLEMS & INDICATE THE NAME OF THE PHYSICIAN TREATING YOU.

ILLNESS OR MEDICAL PROBLEMS	PHYSICIANS TREATING YOU

ILLNESS AND MEDICAL PROBLEMS

PLEASE MARK WITH A (X) ANY OF THE FOLLOWING ILLNESSES & MEDICAL PROBLEMS YOU HAVE OR HAVE HAD. ALSO INDICATE THE YEAR WHEN EACH STARTED. IF YOU ARE NOT CERTAIN WHEN THE ILLNESS STARTED, WRITE DOWN AN APPROXIMATE YEAR.

ILLNESS	X	YEAR	ILLNESS	X	YEAR	ILLNESS	X	YEAR
MIGRAINE HEADACHES			HIGH BLOOD PRESSURE			JAUNDICE		
HEADACHES			HEART ATTACK			LIVER TROUBLE		
HEAD INJURY			HIGH CHOLESTEROL			GALLBLADDER PROBLEMS		
STROKE			POOR CIRCULATION			HERNIA		
SEIZURE			HEART MURMUR			HEMORRHOIDS		
GLAUCOMA			BLEEDING TENDENCY			KIDNEY DISEASE		
OTHER EYE PROBLEMS			ANEMIA			BLADDER DISEASE		
DEAFNESS			OTHER HEART COND.			PROSTATE PROBLEMS		
BRONCHITIS			BREAST CANCER			KIDNEY STONES		
EMPHYSEMA			COLON CANCER			ARTHRITIS		
PNEUMONIA			PROSTATE CANCER			CHICKEN POX		
ALLERGIES			OTHER CANCER			DIABETES		
ASTHMA			ULCER			HEPATITIS		
TUBERCULOSIS			DIVERTICULITIS			MEASLES		
MENTAL ILLNESS			SUBSTANCE ABUSE			PSORIASIS		

ALCOHOLISM			AIDS/HIV			VENEREAL DISEASE		
THYROID DISEASE			RHEUMATIC FEVER					

IMMUNIZATIONS

DATE OF LAST TETANUS SHOT	INFLUENZA VACCINE	GERMAN MEASLES VACCINE

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING, INCLUDING THOSE YOU TAKE WITHOUT A DOCTOR'S PRESCRIPTION (SUCH AS ASPIRIN OR COLD TABLETS).

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.
13.	14.	15.

ALLERGIES AND SENSITIVITIES

LIST ANYTHING THAT YOU ARE ALLERGIC TO, SUCH AS CERTAIN FOODS, MEDICATIONS, DUST, CHEMICALS OR SOAPS, HOUSEHOLD ITEMS, POLLEN, BEE STINGS, ETC. INDICATE HOW EACH AFFECTS YOU.

ALLERGIC TO:	REACTION:	ALLERGIC TO:	REACTION:
1.		5.	
2.		6.	
3.		7.	
4.		8.	

SOCIAL/PERSONAL HISTORY

DO YOU SMOKE? ___YES ___NO IF YES, HOW MANY PACKS PER DAY? _____
ARE YOU A FORMER SMOKER? ___YES ___NO IF YES HOW MANY MONTHS/YEARS SINCE YOU QUIT?

DO YOU DRINK ALCOHOLIC BEVERAGES? ___YES ___NO HOW MANY OUNCES PER DAY? ______
IF YES WHAT TYPE OF ALCOHOL, (I.E. BEER, WINE, LIQUOR)?

____

HOW MANY BEERS DO YOU DRINK PER DAY? ______

DO YOU DRINK COLA, COFFEE OR TEA? ___YES ___NO

DO YOU WEAR A SEAT BELT? ___YES ___NO
DO YOU WEAR SUNBLOCK? ___YES ___NO

DO YOU USE RECREATIONAL DRUGS/NOT PURCHASED AT A DRUG STORE? ___YES ___NO

ARE THERE ANY RELIGIOUS OR CULTURE ISSUES THAT MAY AFFECT YOUR MEDICAL CARE?

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:				HAVE ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING ILLNESSES? IF SO, INDICATE RELATIONSHIP BY PLACING AN "X" IN THE APPROPRIATE BOX:				
RELATIONSHIP:	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FATHER	MOTHER	BROTHER	SISTER
FATHER				HEART DISEASE				
MOTHER				HIGH BLOOD PRESSURE				
BROTHER (S)				CANCER				
SISTER (S)				DIABETES				
SPOUSE				BLOOD DISEASE				
CHILDREN				EPILEPSY				
				RHEUMATOID ARTHRITIS				
				GOUT				
				GLAUCOMA				
				TUBERCULOSIS				

MEN ONLY – ANY PROBLEMS WITH THE FOLLOWING

HERNIA ___ YES ___ NO | PAIN IN TESTICLES ___ YES ___ NO | SEXUAL DIFFIC. ___ YES ___ NO

DISCHARGE FROM PENIS ___ YES ___ NO

SEXUALLY TRANSMITTED DISEASE ___ YES ___ NO

WOMEN ONLY – ANY PROBLEMS WITH THE FOLLOWING

VAGINAL ITCHING/BURNING _____
VAGINAL DISCHARGE _____
PROBLEM WITH MENSTRUAL PERIODS _____
FIRST MENSTRUAL PERIOD _____
DATE OF LAST MENSTRUAL PERIOD _____
DATE OF LAST PAP SMEAR _____
METHOD OF CONTRACEPTION _____
SEXUALLY TRANSMITTED DISEASE _____

SEXUAL DIFFICULTIES _____
NUMBER OF PREGNANCIES _____
NUMBER OF MISCARRIAGES/ABORTIONS _____
NUMBER OF LIVE BIRTHS _____
PROBLEMS WITH PREGNANCIES _____
LUMPS IN BREAST _____
DISCHARGE FROM NIPPLE(S) _____
DATE OF LAST MAMMOGRAM _____

DID YOU MISS MORE THAN (10) DAYS OF YOUR USUAL ACTIVITY LAST YEAR DUE TO ILLNESS OR INJURY?
IF YES, PLEASE EXPLAIN:

____
____
____

PATIENT SIGNATURE ______________ DATE ______________ PHYSICIAN INITALS/DATE ______________