

MEDICAL HISTORY

PATIENT INFORMATION							
LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH / /	SEX M F	MARITAL STATUS S M W D	SPOUSE'S NAME	
ADDRESS		CITY	STATE	ZIP	HOME PHONE () -		
EMAIL		PREFERRED PHARMACY			CELL PHONE () -		
PREFERRED METHOD OF COMMUNICATION: HOME PHONE <input type="checkbox"/> CELL PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL <input type="checkbox"/>					WORK PHONE () -		
PRIMARY LANGUAGE: ENGLISH <input type="checkbox"/> OTHER <input type="checkbox"/>				EMPLOYER (PATIENT)		OCCUPATION (PATIENT)	

CURRENT MEDICATIONS (including over-the-counter)	
(1)	(6)
(2)	(7)
(3)	(8)
(4)	(9)
(5)	(10)

LIST ALL ALLERGIES (MEDICATION, FOOD, PLANT, OTHER)	
(1)	(4)
(2)	(5)
(3)	(6)

SOCIAL HISTORY			
DO YOU SMOKE? YES NO	HAVE YOU EVER SMOKED YES NO	(if yes to either question): HOW MANY PACKS PER DAY? _____	FOR HOW MANY YEARS? _____
DO YOU DRINK ALCOHOL?	YES NO	1 - 7 DRINKS PER WEEK <input type="checkbox"/>	7 + DRINKS PER WEEK <input type="checkbox"/>
DO YOU OR HAVE YOU EVER ROUTINELY USED SMOKELESS TOBACCO?	YES NO	DO YOU OR HAVE YOU EVER USED PRESCRIPTION DRUGS RECREATIONALLY WITHOUT A DOCTOR'S ORDER OR PRESCRIPTION?	YES NO
DO YOU OR HAVE YOU EVER USED ILLEGAL "STREET" DRUGS? (Examples of this would be: Marijuana, Cocaine, Heroine, etc)			YES NO

CURRENT MEDICAL PROBLEMS (for which you are currently being treated)		
(1)	(4)	
(2)	(5)	
(3)	(6)	
DO YOU OR HAVE YOU EVER BEEN TOLD YOU HAVE HEPATITIS C, HEPATITIS B, OR HIV?	YES NO	IF YES: HEPATITIS C <input type="checkbox"/> HEPATITIS B <input type="checkbox"/> HIV <input type="checkbox"/>

SURGICAL HISTORY (Provide year and location of surgeries as this will help us locate your records.)					
SURGERY	LOCATION	YEAR	SURGERY	LOCATION	YEAR
(1)			(4)		
(2)			(5)		
(3)			(6)		

FAMILY HISTORY							
HAS A BLOOD RELATIVE EVER HAD THE FOLLOWING:	CIRCLE APPROPRIATE		IF YES, CIRCLE ALL THAT APPLY				
HEART ATTACK	YES	NO	FATHER	MOTHER	BROTHER	SISTER	
DIABETES	YES	NO	FATHER	MOTHER	BROTHER	SISTER	
COLON CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER	
BREAST CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER	
OVARIAN CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER	
THYROID CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER	

TODAY'S ISSUE / PROBLEM:	
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