PATIENT INFORMATION

☐ Male ☐ Female

Name: _____ Employer: _____

Address: _____ Occupation: _____

City/State/Zip: _____ Work Phone #: ( ) _____

Birthdate: _____ Home Phone #: ( ) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Reason for Today's Visit:

Medical History

MEDICATIONS:

1. Non-Prescription - (✓ Any Taken Regularly)
   - ☐ vitamins
   - ☐ laxatives
   - ☐ decongestants
   - ☐ other: _____
   - ☐ aspirin, bufferin
   - ☐ antacids
   - ☐ Tylenol
2. Prescription - (including Birth Control Pills)

Medication	Dosage	#Times/ Day

IMMUNIZATIONS: (✓ Any Received)

- ☐ Measles
- ☐ Mumps
- ☐ Hemophilus
- ☐ Hepatitis
- ☐ German Measles
- ☐ Smallpox
- ☐ Pneumonia

☐ TB Skin Test: _____ (Year) Pos: ___ Neg: ___

☐ Tetanus Series: (Dates) _____

ALLERGIES: (✓ Any You Are Allergic To)

- ☐ Animals
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Grasses
- ☐ Insect Bites
- ☐ Penicillin
- ☐ Pollens
- ☐ Sulfa

Of the following, are you allergic to: _____

Which Antibiotics? _____

Which Foods? _____

Which Sedatives? _____

☐ Other: _____

☐ No Known Allergies

HABITS:

Do you use tobacco? ☐ Yes ☐ No

☐ Chew ☐ Smoke

If yes, what kind? _____

If yes, how much? _____

Do you drink alcohol?	☐ Yes ☐ No
Do you use drugs?	☐ Yes ☐ No
Do you drink caffeinated beverages?	☐ Yes ☐ No
Do you wear seat belts?	☐ Yes ☐ No
Do you sleep well?	☐ Yes ☐ No
Do you eat well?	☐ Yes ☐ No
Do you exercise regularly?	☐ Yes ☐ No
(Women) Examine breasts monthly?	☐ Yes ☐ No

Have you used narcotics/other addictive drugs? ☐ Yes ☐ No

Types: _____

Have you been exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or/work?

☐ Yes ☐ No How often? _____

Types: _____

Have you experienced any of the following?

- ☐ marriage difficulties
- ☐ sexual difficulties
- ☐ nervous breakdown
- ☐ emotional problems
- ☐ job difficulties
- ☐ sexual attack
- ☐ sleep difficulties
- ☐ depression

List any hospital stays, including surgeries, starting with most recent:

DATE	REASON	HOSPITAL
1.		
2.		
3.		

Have you ever received any blood transfusions? ☐ Yes ☐ No When? _____

Conditions

Check (✓) if you have, or ever had, any of the following conditions:

☐ unexpected weight change of more than 10 lbs. in the past year	☐ changes in appetite
☐ serious problems with eyes or ears	☐ difficulty swallowing
☐ persistent swollen glands/unusual lumps	☐ frequent or severe abdominal pain
☐ breast lump or unusual discharge	☐ frequent nausea or vomiting
☐ irregular or fast heartbeat	☐ frequent or severe constipation/diarrhea
☐ chest pain or tightness	☐ blood in a bowel movement
☐ frequent swelling of ankles or legs	☐ black or tarry stools
☐ unusual or severe shortness of breath	☐ pain or burning with urination
☐ unusual skin problems or persistent sores	☐ loss of control of urination
☐ redness, severe pain or swelling of joints	☐ frequent or severe headaches
☐ frequent or severe back pain	☐ genital problems
☐ other: _____	☐ problems with pregnancy

Family History

Check (✓) if there is anyone in your immediate family with a history of:

☐ asthma	☐ diabetes	☐ mental retardation
☐ birth defects	☐ heart attack	☐ nervous breakdown
☐ bleeding problems	☐ heart disease	☐ seizures
☐ cancer	☐ high blood pressure	☐ stroke
☐ cystic fibrosis	☐ high cholesterol	☐ thyroid problems
☐ depression		

What questions do you wish to ask the doctor?

1. _____

2. _____

3. _____

Do you have a living will? ☐ Yes ☐ No

Signed: _____ Date: _____