Patient Name: _____ Today's Date: _____

Patient Medical History

PLEASE PRESENT THIS COMPLETED FORM TO THE WINDOW IN SUITE A SO THAT IT CAN BE ROUTED TO YOUR NURSE PRIOR TO YOUR APPOINTMENT.

Patient Name: _____ Date of Birth: _____ Age: _____
Last First M.I.

Person completing form if patient is a minor: _____ Relationship: _____

Primary Pharmacy: _____ City of Pharm: _____

Secondary Pharmacy: _____ City of Pharm: _____

ALLERGIES: _____

Medical Diagnosis – Circle all that apply- Please include year of diagnosis, past and present:

Y / N Allergies _____
Y / N Anemia _____
Y / N Angina _____
Y / N Anxiety _____
Y / N Arthritis _____
Y / N Asthma _____
Y / N Atrial Fibrillation _____
Y / N Benign Prostate Hyperplasia _____
Y / N Blood clots _____
Y / N Cancer – Year Diagnosed_____
Type: _____
Y / N Cardiac Arrhythmia _____
Y / N COPD _____
Y / N Coronary Artery Disease_____
Y / N Depression _____
Y / N Diabetes – Year Diagnosed _____
Type: _____

Y / N Elevated Lipids _____
Y / N Gallbladder Disease _____
Y / N GERD _____
Y / N Headache/migraines _____
Y / N Heart Disease _____
Y / N Heart Valve Disease _____
Y / N Hepatitis/Liver Disease _____
Y / N Hypertension _____
Y / N Irritable Bowel Syndrome ____
Y / N Myocardial Infarction _____
Y / N Osteoporosis _____
Y / N Renal Disease _____
Y / N Seizure Disorder _____
Y / N Stroke _____
Y / N Thyroid Disease _____

Other / Explain**:** _____

Surgical History

Type of Surgery	Date of Surgery	Surgeon (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have had more than five major surgeries, please attach list to this sheet. Thank you.

Last Mammogram: ___/___/___ Tdap Vaccine: ___/___/___
Last Pap Smear: ___/___/___ Influenza Vaccine ___/___/___
Last Colonoscopy: ___/___/___ Pneumococcal Vaccine: ___/___/___

Patient Name: _____ Today's Date: _____

Patient Medical History

Family History – (Disease process that could affect you, the patient)

Father - _____
Mother - _____
Sibling(s) - Brother: _____Sister:_____
Child(ren) - Son:_____Daughter_____
Maternal Grandmother -_____
Maternal Grandfather - _____
Paternal Grandmother - _____
Paternal Grandfather - _____

Social History

Do you use tobacco? Y N What type: _____
How much do you chew/smoke per day? _____
Are you a former Smoker? Y N Year you Quit: _____
How many years have/did you smoke/use tobacco? _____
Are you currently using any recreational drugs? Y N Name of Drug/s: _____
Are you a former drug-user? Y N Year you Quit: _____
How many years have/did you use drugs? _____
Do you drink alcohol? Y N How often/amount? _____
Type of alcohol (circle all that apply): Beer Wine Liquor
Do you consume caffeine on a daily basis? Y N Cups per day: _____
Marital Status: Single Married Divorced Separated Widowed
Occupation: _____

Advanced Directives

Living Will	Y	N	Power of Attorney (POA)	Y	N
Do Not Resuscitate (DNR)	Y	N	Name of POA: _____		
Healthcare Proxy	Y	N	Phone Number of POA: _____		
			Relationship of POA: _____		

PLEASE BRING A COPY OF YOUR ADVANCED DIRECTIVES/POA FORM TO YOUR APPOINTMENT.

Consulting Physicians

Please list any other providers you are currently seeing:

Name of Physician	Specialty	Phone Number
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____

Patient Name: _____ Today's Date: _____

Patient Medical History

PEDIATRIC QUESTIONNAIRE

Who does patient live with? (Mother, Father, Stepparents, Grandparents, etc.)

_____

Names of all in household where patient lives	Relationship to Patient	Phone Number
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____
_____	_____	( ) _____-_____

Please list any child care the patient may have (nanny, sitter, day care, mother, father, etc): _____

_____

Are there Smokers at home? Y N Indoor or Outdoor Both

Grade in school _____ School Attending _____

PLEASE BRING A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS TO YOUR APPOINTMENT.