

Date: \_\_\_\_\_

**“PLEASE PRINT”**

PATIENT NAME: \_\_\_\_\_ (mark preferred # with an \*)  
 LAST FIRST MI Home Phone # : \_\_\_\_\_  
 Cell Phone#: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_

NICKNAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ Gender: Male Female  
 Married: Yes No  
 Children: Yes No

E-MAIL: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Referred By: \_\_\_\_\_

MEDICAL PROBLEMS (past or current) e.g.: heart attack, high cholesterol, stroke, arthritis, depression, anemia, asthma, pain, diabetes, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SURGERIES (include year) e.g.: appendix, tonsils, heart bypass, knee surgery, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

CURRENT MEDICATIONS TAKEN (prescription and over the counter include dose):

<u>Drug Name</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

ALLERGIES TO MEDICATIONS: No Yes, please fill in blanks below:

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

OTHER DOCTORS OR SPECIALISTS YOU SEE:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Last Visit: \_\_\_\_\_

HEALTH MAINTENANCE: When was your last?

Physical \_\_\_\_\_

Cholesterol Blood Test \_\_\_\_\_

Colonoscopy \_\_\_\_\_

Bone Density Test \_\_\_\_\_

Upper Endoscopy \_\_\_\_\_

Tetanus Shot \_\_\_\_\_

Pneumonia Vaccine \_\_\_\_\_

Males: Prostate Blood Test (PSA) \_\_\_\_\_

Females: PAP/Pelvic Exam \_\_\_\_\_ Mammogram \_\_\_\_\_

DO YOUR PARENTS OR SIBLINGS HAVE ANY MEDICAL PROBLEMS?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO ANY OTHER MEDICAL PROBLEMS RUN IN YOUR FAMILY? e.g. cancer, heart attack, colon cancer, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE? NO YES FORMERLY

Maximum packs per day \_\_\_\_\_ Number of Years \_\_\_\_\_ When Quit \_\_\_\_\_

DO YOU DRINK ALCOHOL? YES NO If yes, how many drinks per week? \_\_\_\_\_

DO YOU USE ANY OTHER DRUGS? YES NO If yes, what? \_\_\_\_\_

DO YOU HAVE? (circle) LIVING WILL DNR ORDER ADVANCED DIRECTIVES

HOW WOULD YOU LIKE TO BE CONTACTED WITH TEST RESULTS, LABS, ETC.?

Telephone # \_\_\_\_\_ May we leave a message on a machine? YES NO

May we leave a message with a spouse or relative? YES NO

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

OR

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_