PATIENT'S MEDICAL HISTORY

Date: _____ Name _____ Male _____ Female _____ DOB _____

Marital Status _____ Race_____ Primary Language Spoken_____ Patient's Social Security # _____

Address_____ City_____ ST_____ ZIP_____

Home # _____ Cell # _____ Emergency Contact _____ Phone _____

Parent/Guardian name _____ Phone # _____

Responsible Party_____ Relationship to Patient _____ DOB _____ SS# _____

Insurance Company _____ Policy # _____ Other Insurance _____ Policy # _____

Email Address _____Preferred Pharmacy_____

Detailed Reason for Visit Today _____**Weight** _____**Height**_____

Current Medical Issues: circle any current medical issues and list current medications

Fever	Hearing Loss	Irregular Heartbeat	Painful Urination	Anxiety	Cough
Weight Gain / Obesity	Sore Throat	Chest Pain / Pressure	Pelvic Pain	Depression	Wheezing
Weight Loss	Sinus Congestion	Palpitations	Genital Lesion	Memory Loss	Abdominal Pain
Eye Pain	Asthma	Diarrhea	Rash	Pregnant	Cancer
Eye Discharge	Shortness of Breath	Constipation	Mole Change	Breast Feeding	

Current Meds	Dosage/Strength	Current Meds	Dosage/Strength	Current Meds	Dosage/Strength

Medical History:

Please check if you have / had any of the following. Give date of ailment. Advise any ailments afflicting biological parents.

	Self	Mom	Dad	Sibling			Self	Mom	Dad	Sibling
Heart Attack						Migraine				
Heart Disease						Diabetes (Type 1 or Type 2)				
Atrial fibrillation						Asthma				
COPD						Arthritis				
High Blood Pressure						Cancer - What kind?				
Gastro Esophageal Reflux Disease						Cancer (cont'd)				
Splenectomy						Parent Living/Deceased? (L/D)				
List Number of Siblings	Brothers:		Sisters:			Number of Pregnancies				
Siblings Living/Deceased? (L/D)						Number of Deliveries				

I understand that the Family Clinic does not engage in pain management of *any* kind.
If my appointment with the physician requires pain management, the prepaid office visit is non-refundable.

Signature	Printed Name/Date

List **ALLERGIES TO MEDICATIONS** _____ **REACTIONS TO MEDICATIONS** _____

ALLERGIC TO LATEX _____ **ALLERGIC TO TAPE** _____ **ALLERGIC TO IODINE**_____

Surgical History:

Surgery	Date		Surgery	Date		Surgery	Date

Social History:

Do you smoke?		Drink alcohol?		Ever used illegal drugs?	
Amount/Frequency?		Amount/Frequency?		Occupation?	

I, the undersigned, certify that I have answered the above questions truthfully to the best of my abilities.

_____

Responsible Party Signature **Date**

Whom can we thank for the referral? _____