Patient's Name:_________________________________ **Today's Date**: / /20___

Referring doctor/provider:_________________________________

Primary care doctor/provider if different than referring doctor/provider:______________________________

Patient's age: ______ **Reason for today's visit**:____

If you are **female**, are you **pregnant**? ____No ____Yes **Nursing**? ____No ____Yes

Please list any **medication allergy/sensitivity to medication**, including the reaction the medication causes:

____

List ANY **medical problems** you currently have or have had in the past, other than common cold:

1.___________________________ 2._________________________ 3.___________________________
4.___________________________ 5._________________________ 6.___________________________
7.___________________________ 8._________________________ 9.___________________________
10.__________________________ 11._________________________ 12.__________________________

List ANY **operations or surgical procedures** you have had at any time in the past and the **year** the surgery was done, if you can remember:

1.___________________________ 2.__________________________ 3.___________________________
4.___________________________ 5.__________________________ 6.___________________________
7.___________________________ 8.__________________________ 9.___________________________

List **medications** and **dosage** you are currently taking:

1.___________________________ 2.__________________________ 3.___________________________
4.___________________________ 5.__________________________ 6.___________________________
7.___________________________ 8.__________________________ 9.___________________________
10.__________________________ 11._________________________ 12.__________________________
13.__________________________ 14._________________________ 15. __________________________

List reason for any **hospitalizations** and **year** of hospitalization:

1.___________________________ 2.___________________________ 3. ___________________________
3.___________________________ 4___________________________ 5. ___________________________

Social History:

Do you smoke cigarettes? ___No ___Yes If yes, how many cigarettes per day? _____
How long have you been a smoker? _____ years
If you quit smoking, what year did you quit? ________ How long did you smoke before quitting? ____years
How many cigarettes did you smoke per day before quitting? ______
Do you drink beverages containing alcohol? ___No ___Yes
If yes, how many drinks per day? _____ or per week? ______
Recreational Drug usage: ____No ____Yes If yes, type? ____

Family History: Please list any medical conditions or illnesses that your family members had/have:

Mother: ____
Father: ____
Brother(s): ____
Sister(s): ____
Grandmother, paternal: ____
Grandmother, maternal: ____
Grandfather, paternal: ____
Grandfather, maternal: ____
Children:____