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: _____
Grandmother, paternal: _____
Children:_____