



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 \_\_\_\_\_