

Initial History

Patient Name: _____

Sex: Male Female

Date of Birth: _____

Date: _____

Family

Single Married Partner Separated/Divorced Widowed Child

Work History

Are you currently employed outside the home? Yes No

Present type of work: _____

Past Medical History

Anemia	<input type="checkbox"/>	Hereditary Problem	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Asthma/Lung Problem	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Bladder/Kidney Problem	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	Immunity Problem	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Drug/Alcohol Abuse	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>
Ear Problem/Deafness	<input type="checkbox"/>	Neurological	<input type="checkbox"/>
Eczema/Skin Problem	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Emotional/Behavioral	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>
Eye/Visual Problem	<input type="checkbox"/>	Respiratory Infection	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	Stomach/GI Problem	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	Thyroid/Endocrine	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Other	_____		

Past Surgical History

Yes No If 'Yes', please list: _____

Medications: Please list:

Patient Name: _____

Date: _____

Allergies

- None Penicillin Sulfa Codeine Aspirin Iodine Latex Morphine

Other: _____

Review of Systems

Do you smoke? No Yes If yes, how long? _____

How much? half pack pack pack and a half two packs two and half packs three packs
 more

If you have stopped smoking, when did you stop? _____ How long did you smoke? _____

Do you drink alcohol? rarely socially moderately

Do you use recreational drugs? Yes No

What? _____ How Often? Daily Weekly Monthly Seldom

Family History

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia/Blood Disorders |
| <input type="checkbox"/> Asthma/Lung Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |

How were you referred to our office? _____

Family Physician/Medical Doctor

Name _____

Phone Number _____

Address _____

City, State, Zip _____

Revised July 19, 2004