Date:_____ Male Female

Patient Name:_____ Age_____

Height:_____ Weight:_____

Chief Complaint:_____

Current Medications:_____

Allergies Medicine and Other:_____

Medical History:_____

Surgical History:_____

Hospitalizations and Serious Injuries:_____

Female Only: Date of last pap smear_____

Family History:

FATHER: Living Deceased

Cause of Death:_____ Age_____

MOTHER: Living Deceased

Cause of Death:_____ Age_____

BROTHERS and SISTERS: Living Deceased

Cause of Death:_____ Age_____

History of Serious Illness in the Family:(Example: cancer, diabetes, heart disease)_____

_____

Social History:_____

Problem List: Chronic:_____

Acute:_____

(OVER)

PREVIOUS STUDIES

LAST PPD SKIN TEST:_____ normal abnormal

LAST CHEST X-RAY:_____ normal abnormal

LAST EKG:_____ normal abnormal

LAST HEARING TEST:_____ normal abnormal

LAST COLONOSCOPY:_____ normal abnormal

LAST SIGMOIDOSCOPY:_____ normal abnormal

LAST EYE EXAM:_____ normal abnormal

Do you wear contact lenses? YES NO

Do you wear eye glasses: YES NO

IMMUNIZATIONS

TETANUS:_____

PNEUMONIA:_____

FLU SHOT:_____

OTHER:_____