



Name

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
 Chief complaint \_\_\_\_\_

**DRUG ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CURRENT MEDS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HOSPITALIZATION OR SURGERY**

Reason	Date	Reason	Date

**WOMEN ONLY:** Pregnant?  Yes  No Planning pregnancy?  Yes  No

**MEDICAL HISTORY**

<input type="checkbox"/> Headache _____	<input type="checkbox"/> Lactose intolerance _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Shortness of breath _____	<input type="checkbox"/> Gallbladder disease _____	<input type="checkbox"/> Gout _____
<input type="checkbox"/> Heart palpitations _____	<input type="checkbox"/> Prostate disease _____	<input type="checkbox"/> Scarlet fever _____
<input type="checkbox"/> Heart murmur _____	<input type="checkbox"/> Bowel irregularity _____	<input type="checkbox"/> Chronic rashes _____
<input type="checkbox"/> Chest pain _____	<input type="checkbox"/> Incontinence _____	<input type="checkbox"/> Rheumatic fever _____
<input type="checkbox"/> Dizziness/Fainting _____	<input type="checkbox"/> Sexual/menstrual dysfunction _____	<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Peripheral vascular disease _____	<input type="checkbox"/> Venereal disease _____	<input type="checkbox"/> Measles _____
<input type="checkbox"/> Allergies/Hay fever _____	<input type="checkbox"/> Frequent infections _____	<input type="checkbox"/> Rubella _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Polio _____
<input type="checkbox"/> Bronchitis _____	<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Diphtheria _____
<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Tetanus _____
<input type="checkbox"/> Ulcer _____	<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> GI disorder _____	<input type="checkbox"/> Nervousness _____	<input type="checkbox"/> Other _____

**HABITS**

<input type="checkbox"/> Smoke: Packs daily _____ How long _____ Interested in stopping? _____	<input type="checkbox"/> Coffee: Cups daily _____ Other caffeine _____	<input type="checkbox"/> Sleep: Difficulty falling asleep _____ Continuity disturbances _____ Snoring _____ Early morning awakening _____ Daytime drowsiness _____ Other _____
<input type="checkbox"/> Exercise routine: _____	<input type="checkbox"/> Alcohol: Type _____ Amount _____	
<input type="checkbox"/> Contact with blood/bodily fluid at work: _____	<input type="checkbox"/> Diet: Salt intake _____ Fat intake _____	

Children under 18: Height ----Weight-----BP(after 4 yrs)-----  
 Family History of Hereditary disease-----  
 -----  
 Family History of tobacco abuse-----  
 Family History of substance abuse-----  
 Immunization History(Please obtain fom previ ous physician)

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