

PATIENT HISTORY

PATIENT: _____ BIRTH DATE: ____/____/____ TODAY'S DATE: ____/____/____

COMPLAINT (State reason you want to see doctor.): _____

Referring MD or Primary MD: _____ Patient's Phone#: (____) _____

MEDICAL HISTORY

Injuries: _____

Operations/Surgery: _____

Medications: _____

Drug/Food Allergies: _____

Pregnancy History: No. of Pregnancies: _____

No. of Living Children: _____

Complications: No Yes If "yes," Explain: _____

Immunizations: (Up - To - Date) Yes No _____

SOCIAL HISTORY-Check items as appropriate:

MARITAL STATUS

- Single
- Married
- Divorced
- Separated
- Widowed

LIVING ARRANGEMENTS

- Live Alone
- Spouse/Children
- Relative
- Other: _____

PRIMARY CAREGIVER

- Self
- Spouse
- Relative
- Other: _____

ITEMS YOU HAVE BEEN EXPOSED TO:

- Asbestos
- Loud Noises
- Industrial Toxins
- Smoke/Fumes
- Pesticides
- Stress/Pressure
- Heavy Lifting, Physical Strain
- Extreme Heat or Cold
- Other: _____

MAJOR LIFE STRESSES

- School
- Work
- Divorce
- Other: _____

ITEMS YOU NEED ASSISTANCE WITH:

- Bathing
- Eating
- Transportation
- Meal Preparation
- Dressing
- Other: _____

Who provides assistance: _____

MISCELLANEOUS INFORMATION

Occupation: _____

Employer: _____

Employer's Phone: (____) _____

Education: (highest grade completed) _____

Religious Preference: _____

HABITS

Hobbies: _____

Pets: _____

Caffeine: _____

Drugs: _____

Describe Regular Exercise: _____
