PATIENT____

FILE #____

DATE:____

CHIEF COMPLAINT:_____________________________________

HISTORY OF PRESENT ILLNESS:
LOCATION______________________LENGTH OF TIME__________________
SEVERITY______________________

PATIENT MEDICAL HISTORY
DIABETES...........NO YES
HYPERTENSON........NO YES
CANCER.............NO YES
STROKE.............NO YES
HEART TROUBLE......NO YES
ARTHRITIS/GOUT.....NO YES
CONVULSIONS........NO YES
BLEEDING PROBLEM...NO YES
ACUTE INFECTION....NO YES
HEREDITARY DEFECT..NO YES
UNDER DR.CARE______________

SURGERIES (PLEASE LIST)
____
____
____
MEDICATIONS___________________
____
ALLERGIES_____________________
____
BLOOD TRANSFUSION NO YES
INFECTIOUS DISEASE NO YES
WHAT TYPE?____________________

PATIENT SOCIAL HISTORY
MARTIAL STATUS: SINGLE___MARRIED___DIVORCED___WIDOWED___
USE OF ALCOHOL: NEVER____RARELY___MODERATE___DAILY___
USE OF TOBACCO: NEVER____PREVIOUSLY___ CURRENT PACKS/DAY___
USE OF DRUGS: NEVER____TYPE/FREQUENCY__________________

EXCESSIVE EXPOSURE AT HOME OR WORK TO:
FUMES___ DUST___ SOLVENTS___ AIR-BORNE PARTICLES___NOISE___

FAMILY MEDICAL HISTORY--CIRCLE IF APPLICABLE--**CANCER-DIABETES-HEART DISEASE-BLOOD PRESSURE-STROKE**

AGE DISEASES
FATHER ____
MOTHER____
SIBLINGS____
SPOUSE ____
CHILDREN ____
____

I ATTEST THE ABOVE LISTED INFORMATION IS TRUE AND ACCURATE:

____
PATIENT'S SIGNATURE

REVIEWED BY DR. MARY R. McCALLA_______________________

NOTES: