Gifford Health Care

Please bring this completed form, along with your current medications, to you first appointment

Name _____ Date of Birth _____

MEDICAL/SURGICAL HISTORY

In the past twelve months:

1. Have you been hospitalized? ☐ Yes ☐ No
2. Have you had any surgery? ☐ Yes ☐ No
3. Have you had a major illness or accident? ☐ Yes ☐ No
4. Have you had a transfusion? ☐ Yes ☐ N

Do you now or have you ever had:

☐ Diabetes	☐ Heart murmur	☐ Stroke	☐ Hepatitis
☐ High blood pressure	☐ Pneumonia	☐ Crohn's disease	☐ Stomach or peptic ulcer
☐ High cholesterol	☐ Pulmonary embolism	☐ Colitis	☐ Cancer (type):
☐ Hypothyroidism	☐ Asthma	☐ Anemia	_____
☐ Goiter	☐ Emphysema	☐ Jaundice	

Other medical conditions (please list):

_____

SURGICAL HISTORY

1. Procedure:_____ Date: ____/____/____
2. Procedure:_____ Date: ____/____/____
3. Procedure:_____ Date: ____/____/____
4. Procedure:_____ Date: ____/____/____
5. Procedure:_____ Date: ____/____/____

Screenings/Immunizations

Date of last tetanus shot: ____/____/____
Date of last flu shot: ____/____/____
Date of last pneumonia shot: ____/____/____
Date of last bone density scan: ____/____/____
Date of last colonoscopy: ____/____/____
Date of last pap smear: ____/____/____
Date of last mammogram: ____/____/____

FAMILY HISTORY

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Diabetes											
Genetic Disorder											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Mental Illness											
Osteoporosis											
Stroke											
Thyroid Disease											
Other											