Gifford Health Care

Patient Name: _____

D.O.B.: _____

Date of Visit: _____/_____/_____

MR #: _____

Or Affix Patient Label Here

Patient Health History

DO YOU HAVE ANY ALLERGIES OR HAVE YOU HAD ANY BAD REACTIONS TO ANY MEDICINES? Please list:

_____

PLEASE LIST ALL OF THE MEDICINES YOU ARE NOW TAKING:

Name of Medicine	Amount (dose)	How Long?	Dr's Name	Reason

Immunization Status: When was your last Tetanus Vaccine/Booster? _____

Have you had the influenza or pneumovax vaccine? _____ When? _____

BRIEF MEDICAL HISTORY REVIEW:

Have you had or do you currently have:

- Diabetes (sugar)? Yes_____ No_____
- Glaucoma? Yes_____ No_____
- Chronic ear infections/drainage? Yes_____ No_____
- Bleeding History? Yes_____ No_____
- Asthma or hay fever? Yes_____ No_____
- High Blood Pressure? Yes_____ No_____
- Ulcers/stomach or intestinal bleeding? Yes_____ No_____
- Overweight Problems? Yes_____ No_____
- Heart attacks /chest pains? Yes_____ No_____
- Heart murmur/rheumatic fever? Yes_____ No_____
- Seizures (fits)/blackouts? Yes_____ No_____
- Depression for more than one month? Yes_____ No_____
- Do you use tobacco? Yes_____ No_____
  - What type? _____
- Do you drink alcohol? Yes_____ No_____
- Do you have a regular exercise program? Yes_____ No_____
- Major Surgery? Yes_____ No_____
  - If yes, please list: _____
    _____
- Do you wear a seatbelt? Yes_____ No_____
- Do you use "street drugs?" Yes_____ No_____
- Do you have angry, emotional, or abusive exchanges with your spouse? Yes_____ No_____
- Other Relevant History? Please list: _____
  _____
- Do you have children with special problems or difficulty?
- Getting along with family or friends? Yes _____No_____

Personal History: _____

Occupation: _____

Marital Status: _____

Children: _____

PREVENTIVE AND SURVEILLANCE:

When was the last time you:

- If female, had a Pap test? _____
- If female, had a Mammogram? _____
- If female, discussed Breast Self-Exam with doctor? _____
- If 50 or older, had a colonoscopy? _____
- Had an eye exam with glaucoma check? _____
- Had a dental exam? _____

Do you have a family history of:

- Lung cancer or emphysema Yes_____ No_____
- Drug abuse Yes_____ No_____
- Alcoholism Yes_____ No_____
- Suicide Yes_____ No_____
- Diabetes (sugar) Yes_____ No_____
- Glaucoma Yes_____ No_____
- Bleeding disorder or blood disease Yes_____ No_____
- Asthma or hay fever Yes_____ No_____
- Heart attacks or chest pain Yes_____ No_____
- High blood pressure or stroke Yes_____ No_____
- Seizures or convulsions Yes_____ No_____
- Colon or breast cancer Yes_____ No_____
- Depression, suicide or mental illness Yes_____ No_____
- Are you interested in information regarding a Living Will or organ donor? Yes_____ No_____

FEMALES ONLY

- Are you currently pregnant Yes_____ No_____
- Are you currently breastfeeding Yes_____ No_____
- Are you currently on Birth Control Yes_____ No_____
- Other Concerns: _____