

Year	Reason	Hospital

Please list any medications you are currently taking or attach a list		
Name the Drug	Strength	Frequency Taken

  

Allergies to medications		
Name the Drug	Reaction to Medication	Onset Date

PERINENT MEDICAL HISTORY			
<b>Major Injuries</b>	<input type="checkbox"/> Please list, date, and describe any major injuries:		
<b>Diagnostic Testing</b>	Type of Testing:	Date:	Results:
	Chest x-ray		
	EKG		
	MRI (Location): _____		
	CT Scan (Location): _____		
	EEG		
	SPECT Scan		
	PFT		
	Other: _____		
<b>Therapies</b>	Type of Therapy:	Date & Length of Therapy	Progression?

SOCIAL HISTORY	

<b>Alcohol</b>	How often did you have a drink containing alcohol in the past year?		
	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Two to three times per week <input type="checkbox"/> four or more times a week		
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke Cigarettes – # packs/day:
	Former Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> # of years
	<input type="checkbox"/> Year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Have you had a fall within the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear hearing aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear glasses or contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advanced Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, do you have a copy to provide our office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> Paternal		