OAKWOOD FAMILY CARE

Name:_____ Date: _____ DOB: _____ Age:_____ Sex: _____

Purpose of Initial Visit: _____

ALLERGIES

Drug: _____

_____

CURRENT MEDS

Prescription: _____

_____

_____

_____

_____

_____

Over The Counter: _____

_____

_____

FAMILY HISTORY

use check (√) mark for yes answers

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
cancer						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Thyroid Disease						
Drug or Alcohol Addiction						
Other:						

PAST AND PRESENT MEDICAL HISTORY

High blood pressure	Pneumonia	Hemorroids	Skin diseases
Diabetes	Persistant Cough	Gall bladder disease	Blood disorders
Cancer	Tuberculosis	Unexplained Weight gain/loss	Venereal diseases
Chest pain	Abdominal discomfort	Colitis	Anxiety
Chest tightness	Hay fever	Hepatitis or jaundice	Depression
Shortness of breath	Indigestion	Thyroid disease	Anemia
Swollen ankles	Nausea	Head or neck radiation	Alcohol abuse
Palpitations	Vomiting	Headache	Drug abuse
Lightheadedness	Constipation	Kidney disease	Change in bowel habits
Frequent Urination	Diarrhea	Kidney stones	Low back problems
Rheumatic fever	Blood in stool	Difficulty urinating	Other: _____
Asthma	Ulcers	Arthritis	_____
Bronchitis	Gout		_____

PLEASE LIST AND SUPPLY THE DATE OF:

Operations: _____

_____

Hospitalizations other than for surgery: _____

_____

Patient Signature: _____ Date: _____