PATIENT'S NAME_____ DATE: _____

SOCIAL SECURITY NUMBER_____ E-MAIL_____

PATIENT'S MEDICAL HISTORY

Alcoholism___
Allergies/Hay fever___
Anemia___
Anxiety___
Asthma___
Atrial Fibrillation___
Blood Transfusion___
Coronary artery disease___
Cancer___
Cardiac Pacer___
Cardiovascular Disease___
Congestive heart failure___
Cirrhosis___
Colitis___
COPD___
Chronic renal failure___
Crohn's Disease___
Cerebrovascular accident
Depression___
Diabetes Type 1___
Diabetes Type 2___
Epilepsy___
Fracture___
Gastric Ulcer___
Gastrointestinal Disease___
GERD___
Gestational Diabetes___
Glaucoma___
Heart Murmur___
Hepatitis___
High Cholesterol___
Hyperlipidemia___
Hypertension___
Hyperthyroidism___
Hypothyroidism___
Joint Pain___
Kidney Infection___
Kidney Stone___
Migraines___
Multiple Sclerosis___
Obesity___
Old MI___
Osteoarthritis___
Osteoporosis___
Pneumonia___
Progressive Neuro Disorder___
Pulmonary Disorder___
Rheumatic Fever___
Rheumatoid Arthritis___
Sexually transmitted disease___
Terminal Illness___
Thyroid Disease___
Transient ischemic attack___
Tuberculosis___

Other Medical History _____

FAMILY HISTORY

GENERAL FAMILY HISTORY

Adopted___
Denial of any knowledge of significant family history___
Unknown Paternal Hx___
Unknown Maternal Hx___
Alcoholism___
Anemia___
Anxiety___
Asthma___
Birth Defects___
Coronary artery disease___
Cardiovascular Disease___
Congestive heart failure___
Cancer___
Congenital Anomaly___
COPD___
Crohn's Disease___
Depression___
Diabetes___
Epilepsy___
GERD___
Hypercholesterolemia___
Hyperlipidemia___
Hypertension___
Hypothyroidism___
Kidney Disease___
Liver Disease___
Multiple Births___
Osteoarthritis___
Osteoporosis___
Pulmonary Disease___
Stroke___

Other Conditions_____

SURGICAL HISTORY

No Prior Surgical History___

Appendectomy___	Endometrial Ablation___	Laparoscopy___
Breast Lumpectomy___	Gallbladder___	Mastectomy___
Cataract Surgery___	Heart Surgery___	Myomectomy___
Colectomy___	Hemorrhoidectomy___	Oophorectomy___
Cone Biopsy___	Hernia___	Tonsil/Adenoidectomy___
D&C___	Hysterectomy___	Tubal Ligation___

Other Surgical History_____

MEDICATION ALLERGIES	**REACTIONS**
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS	**DOSAGE**	**ORDERING PHYSICIAN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

SMOKING

Current Smoker___ Packs Per Day_____ Years_____

Former Smoker___ Date Quit_____

Never Smoked___

ALCOHOL

Non Drinker___ Occasional___ Social___ Moderate___ Heavy___

CAFFEINE

None___ Servings Per Day_____

MARITAL STATUS:

Married____ Single____ Divorced____ Widow____

DOCTORS (PLEASE LIST ALL)

_____

_____

_____

HEIGHT:_____ WEIGHT:_____ BLOOD PRESSURE: _____ PULSE:_____

PHARMACY:

WHAT **LOCAL** PHARMACY DO YOU USE:

NAME:_____

ADDRESS: _____

PHONE #:_____

WHEN WAS YOUR LAST FLU SHOT? _____

HOW DID YOU HEAR ABOUT DR. JOSEPH TAURO?

_____