DAILEY PEDIATRICS + family medicine

Patient History

NAME:_____

DOB:_____

SEX: M / F

Address: _____

PHONE: Home: _____Cell:_____Work:_____

PHARMACY:_____

Email address:_____

SOCIAL HISTORY: *(please circle)* Marital Status: S/ M/D/W

Race:Caucasion/Black/Hispanic/Aslan/More than 1 race **Ethnicity**: Hispanic/ Non-HIspanic

Illegal Drugs: Y/N **Homosexual**: Y/N **Alcohol** use: Y/N If yes, how many drinks per week?

Tobacco use: Clgarettes___Y/N per month? How many pack per day **Smokeless tobacco** Y/N for how many years?, Former smoker: Number of years quit, (how many packs per day_ forhow many yrs?

List all current medical problems:

List all past medical problems:

LIST ALL DRUG ALLERGIES: *(Includes x-ray dye, etc)*

List all current medications*(including dose, any over the counter medications, and vitamins/herbal supplements)*

FAMILY HISTORY: *Please check if a blood relative has had any of the following.*

Heart attacks/heart disease___ Cancer___ Mental illness___ Stroke ___ Allergies___
Bleeding problems___ High blood pressure___ Kidney stones___ Alcoholism___
Diabetes___ Tuberculosis___ Asthma___ Colon polyps___ AIDS/HIV___ Other___

Relative	Age	Living	Deceased	Cause of Death	Illness
Father					
Mother					
Brother(s)					
Sister(s)					
Children					

LIST ALL PAST SURGERIES:*(list procedure with date)*

HEALTH MAINTENANCE: *Have you had any of the following tests in the past?*

Mammogram (If female) Y /N Date:

Colonoscopy Y/ N Date:

PAP Smear (Ilf female) Y/N Date:

Pneumonia Vaccine Y/N Date:

Bone density testing Y/N Date:

Treadmill Cardiac screening Y /N Date:

PSA/prostate exam (If male) Y/ N Date:

Cholesterol screening Y/N Date: