PATIENT NAME_____ DATE_____

Please fill out this form completely.
Thank you.

REASON FOR VISIT
WHERE IS THE PAIN/PROBLEM?
HOW SEVERE IS THE PAIN/PROBLEM?
DOES THE PAIN/PROBLEM OCCUR AT A SPECIFIC TIME?
WHAT OTHER PROBLEMS HAVE YOU BEEN HAVING?
HOW LONG HAVE YOU HAD THIS PROBLEM?
WHERE WERE YOU AT THE ONSET OF THIS PROBLEM?
COLOR OF SPUTUM (IF ANY)

PAST MEDICAL HISTORY				
PATIENT MEDICAL HISTORY			**PREVIOUS HOSPITALIZATIONS, SURGERIES OR ILLNESS**	
Diabetes	NO	YES		dates
Hypertension	NO	YES		dates
Cancer	NO	YES		dates
Stroke	NO	YES	**ALLERGIES**	
Heart trouble	NO	YES		
Arthritis / gout	NO	YES		
Seizures	NO	YES		
Convulsions	NO	YES	**CURRENT MEDICATIONS**	
Bleeding tendency	NO	YES		
Acute infections	NO	YES		
Venereal disease	NO	YES		
Hereditary defects	NO	YES		

PATIENT SOCIAL HISTORY
MARITAL STATUS: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow
USE OF ALCOHOL: [ ] Never [ ] Rarely [ ] Moderate [ ] Daily
USE OF TOBACCO: [ ] Never [ ] Previously, but quit year [ ]
USE OF DRUGS: [ ] Never Type / Frequency [ ]
EXCESSIVE EXPOSURE AT HOME OR WORK TO:
[ ] Fumes [ ] Dust [ ] Solvents [ ] Air-borne particles [ ] Noise

PATIENT NAME_____ DATE_____

Please fill out this form completely.
Thank you.

PATIENT DEMOGRAPHICAL BACKGROUND (Must select at least one Race and one Ethnicity)	
RACE	**ETHNICITY**
[ ] American Indian or Alaska Native	[ ] Hispanic or Latino
[ ] Asian	[ ] Not Hispanic or Latino
[ ] Black or African American	[ ] Refused to Report / Unreported
[ ] More than one race	[ ] Undefined
[ ] Native Hawaiian	
[ ] Other Pacific Islander	
[ ] Refused to Report / Unreported	
[ ] Undefined	
[ ] White	

LANGUAGE(S) SPOKEN_____

FAMILY MEDICAL HISTORY			
	AGE	**DISEASES**	**CAUSE OF DEATH**
FATHER			
MOTHER			
SIBLINGS			

PHARMACY INFORMATION		
LOCAL PHARMACY	NAME:	PHONE:
	ADDRESS:	
MAIL AWAY PHARMACY	NAME:	PHONE:
	ADDRESS:	

CONTACT INFORMATION		
PREFERRED METHOD OF CONTACT: [ ] Phone [ ] Postal Mail [ ] Email		
PLEASE LIST ANY CHANGES TO THE FOLLOWING:		
NAME:		
ADDRESS:		
HOME PHONE:	WORK PHONE:	MOBILE PHONE:
EMAIL:		