

NAME: _____ DATE: _____

NAME AND RELATIONSHIP OF PERSON GIVING INFORMATION: _____

REASON FOR SEEING DOCTOR TODAY: _____

PATIENT'S GRADE IN SCHOOL: _____

SIBLINGS: BROTHERS/AGES _____

SISTERS/AGES _____

DRUG ALLERGIES: _____

HOSPITALIZATIONS, SURGERIES OR ILLNESSES:

<u>Reason</u>	<u>Age</u>	<u>Reason</u>	<u>Age</u>
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ARE IMMUNIZATIONS CURRENT? YES NO IF NO, PLEASE EXPLAIN? _____

Please Check: (If you currently have problems in any areas listed below)

Weight loss, poor appetite: _____ Kidney/Bladder: _____

Eyes: _____ Endocrine: _____

Ears: _____ Hematological: _____

Nose: _____ Musculoskeletal: _____

Mouth: _____ Neurological: _____

Throat: _____ Psychiatric: _____

Respiratory: _____ Skin: _____

Cardiovascular: _____ Allergy/Immunologic: _____

_____ Digestive System: _____

NEW PATIENTS:

RETURN PATIENTS: HAVE THERE BEEN ANY CHANGES IN FAMILY HISTORY? YES NO

<u>FAMILY HISTORY</u>	<u>FATHER</u>	<u>MOTHER</u>	<u>FATHER'S PARENTS</u>	<u>MOTHER'S PARENTS</u>	<u>SISTERS OR BROTHERS</u>	<u>COUSINS</u>
Childhood Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Congenital Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stillbirths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Unexplained Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
/Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check if Applies: Currently Pregnant? _____ Birth Control Pills: _____

Habits: Exercise: None Rarely Occasionally Daily Competitive Athlete

Sport(s) Player _____

Diet: Usual American Diet Low Fat Low Salt Vegetarian Other _____

Smoking: Yes No If yes, how long? _____ Packs daily? _____

Alcohol: Type/Amount: _____

Reviewed by _____ MD Date: _____