Family Care
Walk-in Clinic

Patient History

Patient Name:	Date of Birth:

Please list any allergies or medicine allergies:

Please list all medications you are currently taking:

Past Medical History (Please check all that apply)						
Diabetes		Asthma		Stomach Problems		Other: (Please list)
Heart Disease		COPD		Psychological		
Kidney Disease		Cancer		Neurological		
Thyroid Disorder		Hypertension		ADD/ADHD		
Seizure Disorder		High cholesterol		STD's		

Pregnancy History:	Births	Miscarriages	Abortions
Please list:			

Gynecological History:	Date of last PAP smear:	History of abnormal? Yes or No
Female Cancers? List:	Date of last Mammogram:	History of abnormal? Yes or No

Surgical History (Please check all that apply)						
Tubal Ligation		Appendectomy		Ear Tubes		Other; (Please list)
Hysterectomy		Tonsillectomy		Vasectomy		
C-Section		Hernia Repair		Heart Surgery		
Cholesectomy		Gall Bladder		Broken Bones		

Family History: (Please check all that apply)	Mother	Father	Mother's Mother	Mother's Father	Father's Father	Father's Mother
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
Arthritis						
Other; (Please list)						

Tobacco Use: YES NO	If yes: How many packs per day?	Alcohol Use: YES NO	Street Drugs: YES NO

Please circle your answer:

Do you have an Advanced Directive or a living will? YES NO

Are your immunizations up to date? YES NO