Last Name:_____

First and Middle Name:_____

Date of Birth(yyyy-mm-dd):_____

Address:_____

Phone Number:_____ Cell Number:_____

Email Address:_____

PHN:_____

Emergency Contact

Name:_____

Phone Number:_____Relationship:_____

New Concerns:

Past Medical Conditions: E.g. diabetes, hypertension? High cholesterol?

Past surgeries?
☐No
☐Yes _____

Social History

Who do you live with?	Occupation (previous if Retired)/Studies?
_____	_____
_____	_____

Any smoking?
☐No
☐Yes, how many packs per day or per week?_____

Any alcohol?
☐No
☐Yes, how many drinks per day or per week?_____

Any drug use?
☐No
☐Yes _____

Family History: (cancer, heart attack, stroke?)
Mother:

Father:

# of brothers and their conditions?

# of sisters and their conditions?

Review of Medications : Please include Name(s), including Dosage(s), and How Many Times Taken Per Day
Current medications?

OTC/ herbal supplements?

Allergies (to medications, food, or environment)?

Immunizations
Are you up to date with immunizations?
☐No
☐Yes

Childhood immunizations?
☐No
☐Yes

Every 10 years tetanus shot?
☐No
☐Yes

Flu shot?
☐No
☐Yes