Today's Date: _____

This form is very important to you and your doctor. We want to double-check all that we know about you as we update our records on a yearly basis. Please spend a great deal of energy filling it out correctly and completely.

Name (Last, First, Initial):_____ Home Number: _____

Cell Phone: _____Email Address: _____Occupation_____

Status: [ ] 1 – Married [ ] 2 – Single [ ] 4 – Other [ ] 6 – Separated [ ] 7 – Divorced [ ] 5 – Widowed

Birthdate: _____ Age _____Sex: _____ Social Security #_____

Medications: (Name, Dose, and when taken)_____

_____

_____

Allergies to medicines: (Yes/No/WhatMedications?)_____

Surgeries: (What did you have and when) _____

_____

Medical History: (List all hospitalizations, or any chronic medical condition for which you've seen a doctor) _____

_____

Social History:
Have you/Do you use illicit/recreational drugs? If so which ones? _____

If you drink alcoholic beverages, how much & how often? _____

If you chew, smoke or have **ever** used tobacco, what age did you start? How much do you use a day? _____
_____

Your Family History: (Any diseases or illnesses in children, parents, or grandparents.)

Name of family member	Age	Health Problems	Cause & Age at Death
Father:			
Mother:			
Siblings:			
Paternal Grandfather:			
Paternal Grandmother:			
Maternal Grandfather:			
Maternal Grandmother:			
Spouse:			
Children:			