PATIENT HISTORY – PLEASE ANSWER ALL QUESTIONS AND RETURN AS SOON AS POSSIBLE.

Name _____ Age _____

Primary Care Physicians _____ Cardiologist _____

PAST MEDICAL HISTORY

Past surgical procedures:

1. _____
2. _____
3. _____

Other Hospitalizations:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current Medical Illnesses:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY HISTORY

Member	Age	State of Health	If Deceased – Cause
Father	____	_____	_____
Mother	____	_____	_____
Brother	____	_____	_____
Sister	____	_____	_____

Is there any family history of the following? (Family Member: Father, Mother, Sister, Brother)

	Cancer	T.B.	High B/P	Kidney Problems	Bleeding Problems	Diabetes	Other
Family Member							
Family Member							

I hereby give my permission for Dr. Hawthorne to examine, treat, and prescribe for the conditions I present to him.

Patient Signature _____ Date _____

Social History

Work in the home _____ Employed _____ (occupation _____) Student ____ Daycare ____ Retired ____

EDUCATION - Highest level of school attended _____

Single ____ Married ____ Separated ____ Widowed ____ Do you live alone? No ____ Yes ____

Children? No ____ Yes ____ #Boys _____ #Girls _____

Exercise? Daily _____ Weekly _____ Monthly _____ Rarely _____ Never _____

What type of exercise? _____

Smoke currently? No____ Yes ____ Pack per day for _____ years.

Drink alcohol? No ____ Yes ____ Daily ____ 1-2 x/week ____ 1-2 x/month ____ 1-2 x-year ____

REVIEW OF SYSTEMS - DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

	Y or N	Describe all yes
Fracture/broken bone		
Sprains		
Dislocation		
Back Injury		
Concussion/Head Injury		
Neck Injury		
Abnormal Thirst		
Night Sweats		
Appetite Good		
Weight Loss		
Impaired Sight/Glasses		
Impaired Hearing		
Headaches		
Nose Bleeds		
Sinus Disorder		
Dentures		
Difficulty Swallowing		
Bleeding Gums		
Frequent Rashes		
Psoriasis		
Eczema		
Frequent Infections		
Swelling of Feet		
Dizziness		
Fainting		
Chest Pain		
Heart Condition		
High Blood Pressure		
Cough		

	Y or N	Describe all yes
Shortness of breath		
Pneumonia		
Tuberculosis		
Spitting up Blood		
Diarrhea		
Rectal Bleeding		
Constipation		
Heartburn		
Black Stools		
Ulcers		
Frequent Urination		
Painful Urination		
Blood in Urine		
Kidney Stones		
Prostate Disorder		
Temporary Paralysis		
Weakness		
Temporary Loss of Sight		
Seizures		
Depression		
Schizophrenia		
Treatment/Hospitalization for Psychiatric Treatment		
Bipolar Disorder		
Drug or Alcohol Abuse		
Hepatitis		
Gallbladder Disease		
Hemorrhoids		

SOCIAL HISTORY CONTINUED

NAME: _____

Race:
_____ American Indian/Alaskan Native
_____ Asian
_____ Black/African American
_____ Native Hawaiian/Pacific Islander
_____ Other
_____ White

Ethnicity:
_____ Hispanic or Latino
_____ Not Hispanic/Latino
_____ Unknown

Tobacco Use: Yes _____ No _____

Contact Information: **Pharmacy Name:** _____ **Phone #:** _____

Pharmacy Address: _____

Lab Preference (Circle One): Quest LabCorp Other

Email Address: _____

Allergies

Medications Name	Reaction

Current Medication

Prescription medication Name	Dosage	Prescribing Doctor