Providence Medical Group/Sunset
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Patient Name:	Date of Birth:	Age:	Sex:	Todays Date:

Patient's Medical History: Has patient ever had? (Circle the appropriate items.)

Alcohol/Drug Abuse	Diabetes	High Blood Pressure	Psychiatric
Asthma	Emphysema	High Cholesterol	Seasonal Allergies
Cancer	Epilepsy	Infectious Disease	Stomach Disorders
Colitis	Heart Disease	Kidney Disease	Thyroid Disease

Immediate Family's Medical History: Blood relatives who currently have or have ever had? (Circle the appropriate items.)

Alcohol/Drug Abuse	Diabetes	High Blood Pressure	Psychiatric
Asthma	Emphysema	High Cholesterol	Seasonal Allergies
Cancer	Epilepsy	Infectious Disease	Stomach Disorders
Colitis	Heart Disease	Kidney Disease	Thyroid Disease

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	_____	**Y/N**	_____	_____
Mother	_____	**Y/N**	_____	_____
Brothers	_____	**Y/N**	_____	_____
Sisters	_____	**Y/N**	_____	_____
Child(ren)	_____	**Y/N**	_____	_____

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
_____	_____	_____
_____	_____	_____

Medication/Food Allergies:

Medication	Reaction
_____	_____
_____	_____

Food	Reaction
_____	_____
_____	_____

(Please see other side)

Medications you are currently taking: (including birth control, over the counter, and herbal meds.)

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dates of your last:

Blood test/Cholesterol level: _____ EKG: _____
Pap Smear: _____ Chest X-ray: _____
Prostate Check: _____ Mammogram: _____
Physical Exam: _____ Tetanus Booster: _____
Glaucoma Check: _____ Pneumovax: _____
Sigmoidoscopy/stool check: _____ Skin Test for TB: _____

Social History:

Marital Status: _____ Occupation: _____ Spouse's Occupation: _____

Do you smoke? **Y/N** If yes, age you started smoking? _____ Year you quit? _____
Packs per day? _____

How much caffeine do you drink? (average number of drinks per day)
None 1 2 3 4 >5

How much alcohol do you drink? (average number of drinks per day)
None Rare<1 Moderate 1-2 High >2

Do you exercise? **None Occasional Moderate Frequent**

Seat Belt Use? **Y or N** Smoke Detector in home? **Y or N**
Bike Helmet Use? **Y or N** Fire Extinguisher in home? **Y or N**

Have you completed an Advance Directive or Living Will? **Y or N**

Have you requested your previous Physician's records? If not, please remember to ask for a Release of Records form while at the front desk.

Thank you for taking the time to complete this form