Sugar Lakes Family Practice Patient Information

NAME______________________________ DATE OF BIRTH____________________

OCCUPATION______________________________ SEX (circle one) FEMALE MALE

EDUCATION (check all) ELEMENTARY HIGH SCHOOL COLLEGE POST GRAD

RELIGION________________________ MARITAL STATUS: S___ M___ D___ W___

CURRENT MEDICATION: ______________

ALLERGIES: ____________________________

SURGERIES: ____________________________

MEDICAL PROBLEMS:

FAMILY MEDICAL PROBLEMS:
Mother: ____________________________
Father: ____________________________
Brother: ____________________________
Sister: ____________________________

DO YOU USE:

TOBACCO OR SMOKE? ________AMOUNT DAILY? ______ HOW MANY YEARS? _______

ALCOHOL? __________QUANTITY PER WEEK? ______________

NUTRITIONAL SUPPLEMENTS? ________ TYPE: ______________________________

RECREATIONAL DRUGS? _______TYPE:______________________________

HAVE YOU HAD A RECENT? (give year) DT______ FLU VAC ______PNEUMONIA VAC_______

FEMALES: LMP__________ NUMBER OF PREGNANCIES:________MISCARRIAGES:_________

CIRCLE ALL THAT APPLY:

Headaches	Chest Pains	Stomach Pains	Anemia
Fainting Spells	Hypertension	Heart burn	Arthritis
Dizziness	Stroke	Nausea/Vomiting	Gout
Blurred Vision	Heart Murmur	Diarrhea	Fractures
Double Vision	Short of Breath	Blood in BM	Glaucoma
Eye Pain	Tuberculosis	Change of Stool size	Cataracts
Ear Aches	Pneumonia	Painful urination	Asthma
Hearing Loss	Hay Fever	Blood in Urine	Cancer
Hoarseness	Cough	Penile discharge	Bypass
Sore Throats	Palpitations	Vaginal Discharge	Asthma
Bleeding Gums	Swollen feet	Loss of Urine/Feces	Colitis
Nose Bleeds	Enlarged Veins	Skin Changes	Seizures

REASON FOR YOUR VISIT: ______________________________ DOCTOR: ______________

SIGNATURE: ____