Nathan C. Jones was born on February 2, 1983. He had surgery when he was 6 years old to have his tonsils removed. He is visiting with his doctor today about frequent headaches and a sick feeling in his stomach. It has been going on for 3 weeks now. He is a truck driver.

Nathan's grandfather had brain cancer and died when he was 82. His father's mother has thyroid problems and high blood pressure. His mother suffers from depression and his sister has diabetes.

Nathan is not currently taking any prescriptions for his headaches, but he would like to get one. He takes 3 aspirin, 3 times a day, but it hasn't helped him. He has no allergies. He has 5 cups of coffee a day.

Nathan is single and occasionally drinks beer with his friends at the bar. He gets second-hand smoke from his roommate, who insists on smoking inside their apartment. He has never done drugs.

Nathan had a concussion on January 1, 2020 after slipping on ice. He also has asthma.

FILL OUT THIS FORM USING INFORMATION FROM THE STORY ABOVE. THERE ARE 2 PAGES.

Name (Last, First MI):	Date of Birth:
Present Health Concerns:	

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis.

☐ Blood Clots	☐ Asthma	☐ High Blood Pressure
☐ Cancer	☐ Hearing Loss	☐ Migraine Headaches
Type:	☐ Heart Problems	☐ Stroke
Date:	☐ Valvular (mitral/aortic)	☐ Thyroid Problems
☐ Concussion	☐ Rhythm (a-fib)	
☐ Depression	☐ Blockage (heart attack)	☐ Other:
☐ Diabetes	☐ Other:	
☐ Type I		
☐ Type II	☐ High Cholesterol	

Surgical History: (Please list all other prior operations and dates)

Operation	Date	Operation	Date

Social History:

Occupation:	Martial Status (circle one) Sgl / Mar / Wid / Div
Advanced Directives: ☐ DNR ☐ Living Will ☐ Power of Atty. Living Arrangements: ☐	Alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Quit Date:_____
Caffeine Intake: ☐ Never ☐ Occasional ☐ Daily	☐ Amount per week:_____
Tobacco: ☐ Current - Type:_____ Freq:_____ ☐ 2nd Hand ☐ Never ☐ Prior Use ☐ Quit Date_____	Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Quit Date: _____ ☐ Type of drug:_____

FAMILY HISTORY:

Relative	Year of Birth	Age of Death	Cause of Death	Health Issues (diabetes, high blood pressure, depression, cancer, etc.)
Father				
Mother				
Siblings (Please circle one)				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Maternal Grandmother / Grandfather				
Paternal Grandmother / Grandfather				
Other				

Medications: Prescriptions and non-prescriptions medicines, vitamins, home remedies, birth control pills, herbs. If more space is needed you can attach a list. **BRING ALL OF YOUR MEDICATIONS TO YOUR FIRST APPOINTMENT.**

Medication	Dose	Times per Day	Prescribed by:

Allergies or Reactions to Medicines/Food/Other Agents: ☐ Check if no allergies

MEDICATION	Reaction or Side Effect