PERSONAL HISTORY

INFORMATION

Patient's Name:_____ **Today's Date:** _____

Date of Birth: _____ **Marital Status:** _____ **Sex:** _____

Address: _____

Phone #:_____ **Health Care #:** _____

Emergency Contact Person: **Name:** _____

Relationship: _____

Phone: _____

CHIEF COMPLAINT: Please describe the reason for your visit today.

MEDICATIONS: Please list the names.

ALLERGIES:_____Yes _____ No

If so, please list: _____

SURGICAL HISTORY: Please list any prior surgeries (include year).

MEDICAL HISTORY: Have you ever had any of the following? When?

Asthma	__ Yes	__ No	Strokes	__ Yes	__ No
Diabetes	__ Yes	__ No	Thyroid Disorder	__ Yes	__ No
Asthma	__ Yes	__ No			
High Blood Pressure	__ Yes	__ No			
Cancer	__ Yes	__ No	If yes, what type?		
Other (please list):					

CLB4 only:

FAMILY HISTORY:

	If living:		If dead:
RELATION	**AGE**	**HEALTH CONDITIONS**	**AGE AT DEATH**
Mother			
Father			
Siblings			

Signature:_____ **Date:** _____

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