APPOMATTOX RIVER MEDICAL

INFORMATION FOR PRIMARY CARE PHYSICIAN DATE _____

Patient's Name _____
(last) (first) (middle) S/S#

Address _____
(street) (city) (state) (zip)

PAST MEDICAL HISTORY
Past and Present Illnesses/Hospitalizations/Surgeries:

| ILLNESS | YEAR | ILLNESS | YEAR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Medications currently being taken (prescription and non-prescription):

| | | | |
|---|---|---|---|
| | | | |
| | | | |

Allergic or bad reaction to medication or anesthesia:

| | | | |
|---|---|---|---|
| | | | |

Bad reaction to insect bites or bee stings? Yes _____ No _____
Special diet? Yes _____ No _____

FAMILY HISTORY

| DISEASE | FAMILY MEMBER | DISEASE | FAMILY MEMBER |
|---|---|---|---|
| ___ Heart Disease | | ___ Stroke | |
| ___ Diabetes | | ___ High Blood Pressure | |
| ___ Breast Cancer | | ___ Bleeding Tendency | |
| ___ Asthma or Hay Fever | | ___ Cancer | |
| ___ Glaucoma | | ___ Kidney Disease | |
| ___ Thyroid Disease | | ___ Lung Disease | |
| ___ Sickle Cell Disease | | ___ | |

SOCIAL HISTORY
_____ Currently Smoke? Packs per day? _____ Do you drink alcohol? _____
How many drinks per day? _____ Do you always wear a seat belt? _____

MEDICAL HISTORY (Circle "Yes" or "No")

| Have you ever had: | | | Year | | | | Year |
|---|---|---|---|---|---|---|---|
| Measles | yes | no | | Bladder infection | yes | no | |
| Mumps | yes | no | | Rheumatic fever | yes | no | |
| Whooping Cough | yes | no | | Kidney disease | yes | no | |
| Polio | yes | no | | Hay fever/sinusitis | yes | no | |
| Scarlet fever | yes | no | | Asthma | yes | no | |
| Diptheria | yes | no | | Emphysema | yes | no | |
| Meningitis | yes | no | | Arthritis | yes | no | |
| Infectious mono | yes | no | | Back trouble | yes | no | |
| High blood pressure | yes | no | | Diabetes | yes | no | |