

PARKWAY MEDICAL PATIENT HISTORY

Name:	Date of Birth:	Age:	Occupation:
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Have you ever had or now have problems with:

	yes	no		yes	no		yes	no
Anxiety / Depression			Heart Trouble			Migraines		
Asthma / Emphysema			Kidney Disease			Thyroid disease		
Bleeding Tendencies			Mental Illness			Bleeding disorder		
Blood clots			Valley Fever			Chronic back pain		
Cancer			Arthritis			Other-		
Diabetes			Seizures					
Glaucoma			Tuberculosis					
High Blood Pressure			STD's					
High Cholesterol			Stroke					

Family History	Age(s)	Medical Problems:
Father		
Mother		
Brothers No: _____		
Sisters No: _____		

Have you ever had any operations? Y N If yes, please list:

Year	Operation	Year	Operation	Year	Operation

List other illnesses **NOT** requiring an operation for which you were hospitalized:

Do you have any **allergies** or sensitivities to medicines or other substances? Y N If yes, please list with type of reaction:

Do you have any religious or cultural beliefs which may affect your care with FamilyCare? Y N If yes, please explain:

Medications, name or otherwise identify over the counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advanced Directive (Living Will) in place? Y N

Tobacco use now Y <input type="checkbox"/> N <input type="checkbox"/>	Past Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:
Alcohol use now Y <input type="checkbox"/> N <input type="checkbox"/>	Past Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:
Marijuana or street drug use now Y <input type="checkbox"/> N <input type="checkbox"/>	Past Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:

Check the disease against which you have been immunized: Hepatitis B Hepatitis A Pneumovax MMR
 Tetanus Polio Diptheria Influenza Other: _____

Date of last Pap smear:	Date of last Mammogram:
Number of pregnancies:	Number of live births:

Are you sexually active? Y N Have you ever experienced any form of abuse? Y N

Have you ever had a blood transfusion? Y N Date: _____

Is there anything that you would like to discuss with your physician in confidentiality? Y N

Patient Signature:	Date:
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Physician/Provider Signature:	Date:
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