BAPTIST Primary Care

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

Age: ____ **Date of Birth:** _____ **Home Phone**: _____ **Cell Phone:** _____

Other treating Physicians: _____

Pharmacy Name and Phone #: _____

Mail Order Name and Phone: _____

History of Present Illness (Describe all in detail what is bothering you, when started, treatments, tests performed)

_____

_____

_____

Past Medical History (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.)

_____

_____

_____

Past Surgical History (List all operations and major injuries)

_____

_____

_____

Allergies and Adverse Reactions (Include allergies to antibiotics, Latex, X-ray, dye, ski preps, pain medications if applicable)

_____

_____

CURRENT MEDICATIONS (Include insulin, steroids, inhalers, oxygen, eye drops, etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency

SOCIAL HISTORY (Circle all that apply)

Marital Status: 1. Single 2. Married
Children: YES ☐ NO ☐ Number of Children _____
Living Will: YES ☐ NO ☐
Occupation: _____
Tobacco: 1. None 2. Currently smoke _____ packs/day and have done so for ____ years
3. Previously smoked _____ packs/day for _____ years. Stopped in _____
4. Smokeless tobacco

Alcohol: 1. None 2. Minimal 3. Moderate 4. Heavy 5. Previously Heavy
Caffeine: 1. None 2. 1-3 servings daily 3. 4-6 servings daily 4. More than 6 servings daily
Drug Use: 1. Marijuana 2. Cocaine 3. Crack 4. Heroin 5. Other (list) _____

FAMILY HISTORY (Please include history of diabetes, heart disease, hypertension, or cancer)

	ALIVE / DECEASED	AGE	HEALTH PROBLEMS
Father			
Mother			
Brothers/Sisters			

Is there a family history of breast or ovarian cancer? (who, at what age, breast or ovarian)

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