Patient Name: _____ Date of Birth: _____

Instructions: For new patients being seen for the first time, please complete entire form. For patients who have completed this form in the past, please add any new information since the last time you filled out the form.

Pharmacy: _____

Allergies (medication, other): _____

Past Hospitalizations/Surgeries (include year):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Current Medications (include vitamins, herbals, birth control, over the counter). Please list dose and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past Medical and Family History: Please circle 'S' for any medical problems you have had and 'F' for any medical problems family members have had (parents, grandparents, aunts, uncles, brothers, sisters):

Alcoholism	S	F	Emphysema	S	F	Lung Disease	S	F
Anemia	S	F	Epilepsy/Seizures	S	F	Major Accidents	S	F
Arthritis	S	F	Gallstones	S	F	Pneumonia	S	F
Asthma	S	F	Glaucoma	S	F	Polio	S	F
Back Pain	S	F	Gout	S	F	Psychiatric Disease	S	F
Blood Disease	S	F	Hard Arteries	S	F	Rheumatic Fever	S	F
Breast Disease	S	F	Headaches/Migraines	S	F	Sex Transmit Infect	S	F
Bronchitis	S	F	Heart Disease	S	F	Sinusitis	S	F
Cancer/Tumor	S	F	Hemorrhoids	S	F	Skin Disease	S	F
Cholesterol	S	F	Hepatitis	S	F	Stroke	S	F
Colon Polyp	S	F	Hernia	S	F	Thyroid Disease	S	F
Depression/Anxiety	S	F	High Blood Pressure	S	F	Tuberculosis	S	F
Diabetes	S	F	HIV/AIDS	S	F	Ulcers	S	F
Diverticulitis	S	F	Kidney Disease	S	F	Urinary Tract Infect	S	F
Ear Infections	S	F	Liver Disease	S	F			

For family medical problems circled above, please indicate which member of the family had the problem and any additional details available:

_____
_____
_____
_____
_____
_____
_____

For All Patients (Date**s** of most recent known exams/tests/immunizations (not done at Generations Family Medicine):

Complete physical exam:	Tetanus vaccine:
Pap smear/pelvic exam:	Flu vaccine:
Stool check for blood:	Pneumonia vaccine:
Colonoscopy:	Hepatitis B vaccine:
Chest Xray:	Shingles vaccine:
EKG:	Covid vaccine:
Eye exam:	TB skin test:
Dental exam:	Blood tests:

For Women Only:

Age at first period:	Number of pregnancies:
Age at final period:	Number of miscarriages:
First day of most recent period:	Number of live births:
Length of time between periods:	Have you ever used contraceptive pills? Yes No
How long to periods last?	Current contraception:
Date of last mammogram:	Previous abnormal pap smear? Yes No

Prevention Measures:	**YES**	**NO**
Do you perform self-breast exams (women)?		
Do you perform self testicle exams (men)?		
Do you perform self-skin exams?		

Personal History:
Highest school grade level achieved: _____
Occupation: _____
Marital Status: _____ Married _____ Separated _____ Divorced _____ Widowed _____Single
Number and age of children: _____

Social History	**YES**	**NO**	**HOW MUCH PER DAY?**	**QUIT DATE?**
Alcohol				
Tobacco				
Caffeine				
Exercise				
Marijuana/Heroin/Cocaine (circle which)				

Signature: _____ Dated: _____