



INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination. It will help your physician to know not only about your health but also about your family and relatives.

TODAY'S DATE

214379-1

NAME ADDRESS

TELEPHONE NUMBER DATE OF BIRTH AGE PLACE OF BIRTH RACE OR NATIONALITY OF PARENTS

RELIGION EDUCATION (Highest level attended) OCCUPATION HOW LONG

PRESENT MARRIAGE (Year Married) PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

Table with columns for FATHER, MOTHER, SPOUSE, BROTHERS, SISTERS, CHILDREN, including sub-columns for health status and cause of death.

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES... CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD... LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.
No Yes LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
No Yes LIST:

DO YOU USE TOBACCO NOW? IN THE PAST? TYPE AND DAILY AMOUNT HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES? TYPE WEEKLY AMOUNT HOW LONG?
DO YOU DRINK COFFEE? WEEKLY AMOUNT HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED Smallpox Tetanus Typhoid Polio Influenza Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD PERIODS ARE NUMBER OF PREGNANCIES NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ORAL CONTRACEPTIVES? HAVE YOU RECEIVED A BLOOD TRANSFUSION? DATE:

DRESSED WEIGHT HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) DATE