Room

Last Name: ______________________ First Name: _______________ DOB_________

Reason for visit____

Preferred Pharmacy ________________________Location_____________________

Primary Care Physician____
How did you hear about us? ____
DRUG ALLERGIES____
Please list **All** current medication taken: ____

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LAST TETANUS SHOT? (*Women*) Last Menstrual Period

Past Medical History	***(Circle)***	***Past Surgical History***	***Date***
None		***None***	
High Blood Pressure	*Asthma*	*Open Heart*	***Other***
Diabetes	*Cardiac Disease*	*Angioplasty*	
Chronic Bronchitis	*Stroke*	*Gall Bladder*	
Emphysema	*Cancer*	*Back or Knee*	
Seizures	*Thyroid*	*Appendectomy*	
Other	*High Cholesterol*		

Social History
Do you smoke? _________If yes, How much and how many years? ___________________
Do you drink Alcohol? ________If yes, How much per week? _______________________
Do you take drugs not prescribed to you? ____

Family History **Which family member for each**? (Please circle)
Diabetes *Coronary Artery Disease* *Cancer (type)*___________________
Stroke *High Blood Pressure* *Other*____________ *None*

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Nurse Use Only

Do you need a note for work or school today? Yes____No____

Vital Signs
BP_____________
Pulse___________
Resp.___________
Temp__________ oral –axillary-tympanic-rectal
Weight _________children and physicals weight

O2 Sat ______%
Pain Level ________
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