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 ________

2/11/16
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