Dear Patient: Southview is converting over to an Electronic Medical Record system. Please help us by filling out this form to the best of your knowledge.

(Do not be concerned if you do not know the answers.)

NAME:____**BIRTHDATE**__________________

ADDRESS:____

PHONE: HOME ( ) ________________WORK: ( ) ____________________CELL: ( )____________________

Please circle any illness you have had:

Anxiety	Gonorrhea	Jaundice	Osteoporosis
Asthma	Gout	Kidney Disease	Rheumatic Fever
Bleeding Tendency	Heart Disease	Kidney Stones	Rheumatoid Arthritis
Cholesterol	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis	Lung Disease	Syphilis
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble

Diabetes (if yes, how long) __________________ **Cancer (if yes, where)** ________________________________

Other illnesses____

Previous Surgery/Injuries (and date):____

____

FAMILY HISTORY:

Father: Alive? Y or N Illnesses: ______________________Age at death_____ Cause_______________________

Mother: Alive? Y or N Illnesses: ______________________Age at death_____ Cause_______________________

Siblings/Health____

Children/Health____

SOCIAL HISTORY: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Living with:** _____________________________

HABITS: Smoking Y or N Packs a day____ How long ____ Alcohol Y or N drinks/day average__________

Substance abuse Y or N _________

Occupation___________________________________ **RELIGION:** _____________________

MEDICATIONS: NAME/DOSE/HOW IT'S TAKEN NAME/DOSE/HOW IT'S TAKEN

1. ____ 6. ____
2. ____ 7. ____
3. ____ 8. ____
4. ____ 9. ____
5. ____ 10. ____

Drug Allergies:____

Other Physicians seeing you currently:____ _____________

Last Colonoscopy: __________ **Findings:** ______________________ **Performed by:** _____________________________

Immunizations and date: **Gardisil**_________ **Hepatitis B**_________ **Influenza**_________ **Pneumovax**_________

Measles_________ **Menningococcal**________ **Rubella**_________ **Tetanus**_________ **Zostavax**_________

CONSTITUTIONAL: ☐ fevers/chills ☐ night-sweats ☐ anorexia ☐ weight loss

EYES: ☐ blurry vision

EARS, NOSE, MOUTH & THROAT: ☐ decreased hearing ☐ runny nose ☐ mouth sores ☐ sore throat

CARIOVASCULAR: ☐ chest pain ☐ palpitations ☐ decreased exercise tolerance

RESPIRATORY: ☐ cough ☐ shortness of breath

GASTROINTESTINAL: ☐ nausea/vomiting ☐ difficulty swallowing ☐ heartburn ☐ diarrhea ☐ constipation

☐ blood in stool ☐ hemorrhoid problems ☐ abdominal pain

MUSCULOSKELETAL: ☐ joint pain/swelling ☐ weakness

DERMATOLOGIC: ☐ rashes ☐ jaundice

NEROLOGIC: ☐ numbness/tingling ☐ difficulty speaking ☐ difficulty walking ☐ decreased sensation ☐ weakness

PSYCHIATRIC: ☐ depression ☐ anxiety ☐ difficulty sleeping

HEMATOLOGIC: ☐ anemia ☐ easy bruising

PHARMACY INFORMATION:

Pharmacy Name: ___________________________**Location:**________________________**Phone Number(___)**___________

Signature: ____ Date: ____/____/____

Physician: ____ Date: ____/____/____