PATIENT GENERAL INFORMATION

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Date:	

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

*NAME			*DATE OF BIRTH:	
OCCUPATION			Native Hawaiian/Other Paci	fic Island
MARRIED WIDOW (ER)			AsianAmerican Indian/Al	
INGLE DIVORCED			Other	
OMESTIC PARTNER			*ETHNICITY:	
			i.eEuropean, German, Mexican etc *PREFERRED LANGUAGE:	
PERSONAL HEALTH	ністоі	ρV	DATE OF DIAGNOSIS (OR APPROXI	MATF)
Heart attack / angina	NO NO	YES	DATE OF DIAGNOSIS (OR AFTROMI	MAIL)
Heart failure	NO	YES		
Stroke	NO	YES		
High blood pressure	NO	YES		
High cholesterol	NO	YES		
Asthma	NO	YES		
COPD or emphysema	NO	YES		
Colitis or bowel disease	NO	YES		
Liver disease	NO	YES		
Kidney disease	NO	YES		
Bone or joint disease	NO	YES		
Diabetes	NO	YES		
Thyroid disease	NO	YES		
Migraines	NO	YES		
Allergies	NO	YES		
Skin disease	NO	YES		
Cancer	NO	YES		
Depression	NO	YES		
Anxiety	NO	YES		
Sexually transmitted disease	NO	YES		
Other	NO	YES		
SURGERIES AND DATES PERI	ORMEI	D	HOSPITALIZATIONS OTHER THAN SU	RGERIES
		н	TORY OF INJURIES:	
Broken Bones		NO	YES SPECIFY	_
Dislocations		NO	YES SPECIFY	<u></u>
Concussion, or Head Inju	ry	NO	YES SPECIFY	_
DO YOU SMOKE TOBACCO?		NO	YES PACKS PER DAY	
HAVE YOU EVER SMOKED TO	BACCO		YES HOW LONG	
DO YOU DRINK ALCOHOL?	<i>D</i> 11000	NO NO	YES DRINKS PER WEEK	
DO YOU DRINK CAFFEINATE	D DRINK		YES CUPS PER DAY	
	\-		(INCLUDING COFFEE, TEA, & COLA)	

DRUG ALLERGIES

	LUNGTER	AVI PRESCH	RIPTION MEDICATION	YUU:
ARE CURREN	TLY TAKIN	G	HAVE	TAKEN IN THE PAST
				
				
			SMA TRANSFUSION?	
HAVE IOU EVE	EK HAD BLU	OD OK PLA	SWA I KANSCUSIUN!	
DATE OF LAST	DIPHTHERIA	-TETANUS	BOOSTER	
		1	WOMEN:	
Date of last me	enstrual period		what kind?	
Do you use bir	th control?	If yes,	what kind?	
Date and result	of last Pan Sr	near Date	Result	
Date and result	of last Pap Sr	near Date	Result	
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PLEASE PROVIDE S.A.M.C. WITH COPIES OF ANY ADVANCED DIRECTIVE SUCH AS MEDICAL POWER OF ATTORNEY, DNR, ETC.

WHO_ WHO_

WHO___

WHAT_

WHAT

_____ WHAT_

NO

Other diseases

YES