TODAYS VISIT

This form MUST be filled out <u>on the day</u> of your appointment.

_____
Appointment Date

Patient Name:_____ Reason for Visit: _____

Medical Diagnosis: (ie..hypertension, high blood pressure, acid reflux, etc…)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

<u>PAST PROCEDURES/SURGERIES</u>:	**<u>DATE</u>:**	**<u>NON-SURGICAL HOSPITALIZATIONS</u>:**	**<u>DATE</u>:**
1. _____	_____	1. _____	_____
2._____	_____	2._____	_____
3._____	_____	3._____	_____
4._____	_____	4._____	_____
5._____	_____	5._____	_____

FAMILY HISTORY:

	<u>Age</u>	<u>Alive/Deceased</u>	<u>Cause of Death</u>		<u>Age</u>	<u>Alive/Deceased</u>	<u>Cause of Death</u>
MOTHER:	_____	A/D	_____	FATHER:	_____	A/D	_____
Any Illness:_____				Any Illness:_____			
Brother(1)____		A/D	_____	(2)_____		A/D	_____
(3)____		A/D	_____	(4)_____		A/D	_____
Any Illness:_____				Any Illness:_____			
Sister(1)_____		A/D	_____	(2)_____		A/D	_____
(3)_____		A/D	_____	(4)_____		A/D	_____
Any Illness:_____				Any Illness:_____			

Children:

Son: (1)_____ A/D _____ (2)____ A/D _____

(3)_____ A/D _____ (4)____ A/D _____

Any Illness:_____ Any Illness:_____

Daughter(1)____ A/D _____ (2)_____ A/D _____

(3)____ A/D _____ (4)_____ A/D _____

Any Illness:_____ Any Illness:_____

IMMUNIZATIONS: Date: Drug Allergies:

___ Influenza _____ _____

___Pneumonia _____ _____

___Tetanus _____ _____

___Diptheria _____ _____

___TB Skin Test _____ _____

___Other _____ _____

Social History:

Where were you born?_____

How long in Metroplex?_____

Married? Yes / No How many time? _____ Divorced? Yes/NO Widowed?_____ Never Married?__

Working? _____ Not Working?_____ Retired?_____

Profession?_____

MEDICATIONS: (PLEASE INCLUDE---- mg / dose / times per day)

_____ _____ _____

_____ _____ _____

_____ _____ _____