



# WAKE FOREST FAMILY PHYSICIANS



## PATIENT HISTORY FORM

DATE: \_\_\_\_\_

MRN #: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

### Medical History:

Have you ever had any of the following? (Please check ALL that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Smoke                             | <input type="checkbox"/> Back Problems                         | <input type="checkbox"/> Allergies to Medicine or Drugs |
| <input type="checkbox"/> Use Alcohol                       | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> General Allergies              |
| <input type="checkbox"/> Drug Use                          | <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Blood Diseases                 |
| <input type="checkbox"/> Heart Problems                    | <input type="checkbox"/> Emphysema                             | <input type="checkbox"/> Arthritis                      |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Epilepsy                              | <input type="checkbox"/> Rheumatic Fever                |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Headaches                             | <input type="checkbox"/> Sinus Problems                 |
| <input type="checkbox"/> Circulatory Problems              | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease | <input type="checkbox"/> AIDS or other                  |
| <input type="checkbox"/> Nervous Problems                  | <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Immunosuppressive Disorder     |
| <input type="checkbox"/> Radiation Treatment               | <input type="checkbox"/> Psychiatric Care                      | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Chronic Diarrhea                      | <input type="checkbox"/> Ulcer                          |
| <input type="checkbox"/> Recent Weight Lose                | <input type="checkbox"/> Allergies to Anesthetic               | <input type="checkbox"/> Sexually Transmitted Diseases  |

What Surgeries have you had? \_\_\_\_\_

Do you have any drug allergies or have your ever had a bad reaction to any medications? Yes No

If yes, what? \_\_\_\_\_

Have you ever responded badly to medical or dental treatment? Yes No

If yes, what? \_\_\_\_\_

### PRESENT MEDICATIONS:

(Please include vitamins and herbs)

Medication Name	Dosage (mg/ml)	How often do you take?	Why?

### Family Medical History:

Mothers Medical History: \_\_\_\_\_

Fathers Medical History: \_\_\_\_\_

Siblings Medical History: \_\_\_\_\_

Maternal Grandparents Medical History: \_\_\_\_\_

Paternal Grandparents Medical History: \_\_\_\_\_

Is there anything else we should know about your medical history? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_