

CHADWICK MEDICAL ASSOCIATES, P.C.
PATIENT INFORMATION

Patient's Name _____ Date _____ Marital Status _____

Date of Birth: _____ Sex _____ Health Care Proxy _____ Yes _____ No

1. Family History

	Living		Deceased	
	Age	Health	Age	Cause
Father				
Mother				
Brother				
Sister				
Spouse				
Children				
Name of Employer:		Position held:		
Recreation				
Exercise				
Hobbies				

2. Have you every had? (Please check if yes)

Bleeding Tendency		Diabetes	
Kidney Disease		Jaundice	
High Blood Pressure		Migraine	
Nervous Breakdown		Hay Fever	
Epilepsy		Asthma	
Heart Attack		Cancer	
Arthritis		Anemia	

3. Do you use any of the following? (Please check if Yes)

Tobacco _____ Alcohol _____ Coffee/Tea _____ Other Substances _____

4. Are you presently taking any of the following medications (Please check)

Aspirin, Bufferin, Anacin	_____	Tranquillizers	_____
Blood Pressure Pills	_____	Diet Pills	_____
Cortisone	_____	Blood Thinners	_____
Digitalis	_____	Dilantin	_____
Hormones	_____	Shots	_____
Insulin or Blood Medications	_____	Antibiotics	_____
Laxatives	_____	Birth Control Pills	_____
Sleeping Pills	_____	Other Drugs:	_____

5. Surgical and Hospitalization History (List year and procedure or reason)

6. Do you have any Drug Allergies YES _____ NO _____

If yes list name of Drug and type of reaction:

7. In your own words, please state what your current medical problem is:
