

STAR FAMILY MEDICINE MONICA MIHALACHE, MD

INITIAL PATIENT HISTORY	NAME
	DOB/AGE:
	INFORMANT:

PAST MEDICAL HISTORY/DIAGNOSIS

<u>SURGERIES/PROCEDURES</u>	<u>DATE</u>	<u>HOSPITALIZATIONS</u>	<u>DATE</u>
1 _____	_____	1 _____	_____
2 _____	_____	2 _____	_____
3 _____	_____	3 _____	_____
4 _____	_____	4 _____	_____

<u>FAMILY MEDICAL HISTORY</u>	<u>MEDICATION ALLERGIES</u>	<u>REACTION</u>
MOTHER: _____	1 _____	_____
FATHER: _____	2 _____	_____
SIBLINGS: _____	3 _____	_____
CHILDREN: _____	4 _____	_____
OTHER: _____	5 _____	_____

CURRENT MEDICATION, DOSAGES AND INSTRUCTIONS

1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____

SOCIAL HISTORY CIRCLE ONE: SINGLE MARRIED SEPERATED DIVORCED WIDOWED SIGNIFICANT OTHER

WITH WHOM DO YOU LIVE? _____ RELIGIOUS PREFERENCE: _____

ARE YOU EMPLOYED? NO ___ PART TIME ___ FULL TIME ___ JOB TITLE: _____ DISABLED (REASON) _____

TOBACCO: NEVER SMOKED ___ QUIT ___ YEARS AGO #YEARS SMOKED ___ #PACKS PER DAY ___ OTHER FORM OF TOBACCO ___ DO YOU WANT TO QUIT? _____

ALCOHOL: NEVER ___ QUIT ___ YEARS AGO 1DRINK /MONTH ___ 1 DRINK/WEEK ___ 1 DRINK/DAY ___ OTHER ___ DO YOU WANT TO QUIT ? _____

RECREATIONAL DRUGS: NEVER ___ QUIT ___ YEARS AGO CURRENTLY USE ___ HISTORY OF IV DRUGS ___ TYPE _____ DO YOU WANT TO QUIT ? _____ DO YOU HAVE AN ADVANCED DIRECTIVE? ___ DO YOU WEAR A SEAT BELT? ALWAYS ___ SOMETIMES ___ NEVER _____

MOST RECENT VACCINES: TETANUS _____ (Date) PNEUMOVAX _____ (Date) FLU SHOT _____ (Date) TB TEST _____ (Date) **OR**-PATIENT/INFORMANT

SIGNATURE _____ DATE _____

Physician Signature _____