WRIGHTSTOWN FAMILY MEDICINE

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Sex: Male Female Date of Exam: _____

MEDICAL AND SURGICAL HISTORY *(any ER visits or hospitalizations)*

_____

_____

_____

_____

_____

CURRENT MEDICATIONS *(Attach a second page if needed)*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: _____

Smoke: y / n How much? _____ **Alcohol:** y / n How much? _____ **Drugs:** y / n _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years):* _____/_____/_____

Hepatitis B: _____/_____/_____ _____/_____/_____ _____/_____/_____

Flu Shot: _____/_____/_____ **Pneumovax:** _____/_____/_____

Other *(specify)* _____

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: **Date:** _____ **Results:** _____

Mammogram: **Date:** _____ **Results:** _____

DEXA Scan: **Date:** _____ **Results:** _____

Colonoscopy: **Date:** _____ **Results:** _____

Hemoccult: **Date:** _____ **Results:** _____

PSA: **Date:** _____ **Results:** _____

FAMILY HISTORY: Anyone with heart attacks, strokes, high blood pressure, diabetes, asthma, colon cancer, breast cancer, ovarian cancer, prostate cancer, etc

Father _____ **Paternal grandparents** _____

Mother _____ **Maternal grandparents** _____

Siblings _____ **Other** _____

REVIEW OF SYMPTOMS: circle if you have any of the following

Fever Chills Malaise and Fatigue Hair Loss Weight Loss Nausea Vomiting Diarrhea Constipation

Abdominal Pain Vision Issues Hearing Issues Headaches Joint Pains Urinary symptoms Weakness