FAITH FAMILY
MEDICAL CENTER

DATE: _____

PATIENT INFORMATION

Name	Date of Birth

LIVING ARRANGEMENT

☐Single ☐ Married w/ children ☐ Married w/o children ☐ Divorced ☐Other_____

PERSONAL MEDICAL HISTORY (Please check past or present history of the following conditions:)

Past	Present	Condition	Past	Present	Condition
☐	☐	Abnormal Pap Smear or Mammogram	☐	☐	Hernia
☐	☐	AIDS/HIV	☐	☐	High Blood Pressure
☐	☐	Alcohol/Drug Problems	☐	☐	High Cholesterol
☐	☐	Anemia/Bleeding Problem	☐	☐	Infertility (difficulty getting pregnant)
☐	☐	Arthritis/Gout	☐	☐	Kidney/Bladder Problems
☐	☐	Blood Clots	☐	☐	Liver Disease/Jaundice/Hepatitis
☐	☐	Cancer (Type:_____)	☐	☐	Mental Trouble/Depression/Anxiety
☐	☐	Cataracts/Vision Loss/Glaucoma	☐	☐	Rheumatic Fever
☐	☐	Circulation Problems	☐	☐	Seizures/Fits/Epilepsy
☐	☐	COPD/Emphysema/Asthma/Pneumonia	☐	☐	Serious Injury/Accident
☐	☐	Diabetes (sugar)	☐	☐	Sickle Cell Anemia
☐	☐	Eating Disorder (anorexia/bulimia)	☐	☐	Skin Disorders
☐	☐	Genital Herpes/Infections/Warts/GC	☐	☐	Stroke
☐	☐	Hay Fever/Pollen Allergy	☐	☐	Thyroid Problem
☐	☐	Headaches	☐	☐	Transfusion (year:_____)
☐	☐	Hearing Loss	☐	☐	Tuberculosis (TB)
☐	☐	Heart Attack/Heart Disease	☐	☐	Ulcers
☐	☐	Heart Murmur	☐	☐	Other (specify:_____)
☐	☐	Hemorrhoids/Polyps (Colon)			

PAST SURGERIES, SERIOUS INJURIES, OR PREGNANCIES_____

_____

PERSONAL HABITS:

Past or present use of tobacco products? ☐ Yes ☐ No (If so, please list what kind, how much, how long, and date last used.)

_____

Past or present use of alcohol? ☐ Yes ☐ No (If so, please list how much and how often.)

_____

Past or present use of street drugs? ☐ Yes ☐ No (If so, please list what kind and how often.)

_____

FAITH FAMILY
MEDICAL CENTER

DATE: _____

Do you have an advanced directive? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY: (Cancer, heart trouble, high blood pressure, diabetes, TB, blood problems, any other problems in parent, grandparents, siblings, and/or children)

ALLERGIES:

MEDICATIONS PRESENTLY BEING USED: (prescriptions, over-the-counter, and/or alternative)

IMMUNIZATIONS: Last Tetanus? _____ Pneumovax? _____
WOMEN ONLY: Last PAP Smear? _____ Last Mammogram? _____

PREFERRED PHARMACY: