Initial History

Patient Name:____Date of Birth_______
Address:_______________________________Town:___________State____Zip_______
Phone: ( )_________________
Residence: ____________Live alone _______________Live with others

Relative/ Friend Contact:___________________________Relationship:_______________
Address:___________________________Town:__________State:______ Zip:_________
Phone: ( )____________
Pharmacy: _________________________Town:______________Phone:( ) _________

Current and Past Medical History

What are your current medical concerns?____
____
____

How is this problem affecting your daily life?___________________________________
____
____

Do you presently have any other medical problems?______________________________
____
____

List any Surgical Procedures you have had

Procedure	Date
a)____	_________________
b)____	_________________
c)____	_________________
d)____	_________________

List all the medications you care presently taking; both those you take daily and those you just take once in a while. Please include Vitamins, mineral supplements, laxatives, stool softeners, and prescription skin preparations. If you cannot remember the names write a '?" and bring the medicines with you to your next visit.

Medicine name	Strength	How Often	Reason
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________

List any allergies you have, including drug allergies:______________________________
____

How do you rate your health?
________excellent ________ good __________fair _________poor _________bad

Falls

Have you fallen in the past year? ____Yes ____No
Have you cut down your activities because of a fall? ____Yes ____No
If "yes" what are they:____
____

Alcohol
Have you ever felt you should cut down on your drinking? ____Yes ____No
Have people annoyed you by criticizing your drinking? ____Yes ____No
Have you ever felt bad or guilty about your drinking? ____Yes ____No
Have you ever had a drink first think in the morning to steady your nerves or get rid of a hangover? ____Yes ____No

Smoking
Current smoker__________
Former smoker__________ stopped in year of _________
Never smoked__________

Are you on a special diet? _____Yes ____No
If "yes" please describe: ____
____
____

A Little About You

Do you have any hobbies? List two thinks that you particularly enjoy.

1)

2)

Please list three interesting things about yourself. For example, "Is a life long Boston Red Sox Fan" or "Was a teacher."

1)

2)

3)