Sanford Medical Group (A Clinic of Pinehurst Medical Clinic)

Patient name: _____ **Date:** _____

Past Medical History and Family Medical History **Date of Birth:** _____

INSTRUCTIONS: The following list of questions will help us give you better medical care. Please answer these questions and circle the correct answer. The nurse will help you with any questions you do not understand.

1. Do you have hay fever, asthma, or other allergies? Yes No
2. Have you had an allergic reaction to any medications? Yes No
   Specifically, have you had a reaction to: Penicillin, Sulfa drugs, tranquilizers?
   Sleeping pills, Novocaine, other local anesthetics, or any other medication? Yes No
3. Do you ever drink alcoholic beverages? Yes No
4. Do you smoke cigarettes? Yes No
5. Have you ever had any type of operation or surgery? Yes No
   If yes, please record date and type of operation._____
   _____
6. Have you been admitted any other times to a hospital? Yes No
   If yes, record date & reason. _____
   _____
7. Have you had any of the following illnesses: (Please circle those that apply)

Diabetes	Hepatitis	Cancer	Epilepsy
Stroke	Bleeding Trouble	Back Trouble	Asthma or related disorders
Venereal Disease	Heart Attack	Kidney Disease	
Skin Trouble	High Blood Pressure	Ulcers of Stomach	

8. Have you had any serious injuries or broken bones? Yes No
9. Family History:

	Age, if living	State of Health	Cause Of Death	Age at Death
Father----------				
Mother ----------				

*Number of brothers_____Living_____Dead_____*Number of sisters _____ Living _____Dead ___

10. Have any of your blood relatives had any of the following diseases: (Please circle those that apply & list relation)

Anemia_____	Emphysema_____	Migraine Headaches_____
Arthritis_____	Epilepsy_____	Nervousness_____
Allergies_____	Gout_____	Stomach Ulcer_____
Asthma _____	Heart Attack _____	Stroke_____
Alcoholism _____	Birth Defects _____	Suicide _____
Cancer _____	High Blood Pressure _____	
Thyroid Disease _____	Leukemia _____	Tuberculosis_____
Liver Cirrhosis_____	Heart Disease _____	Kidney/ Stone Trouble_____
Diabetes_____	Mental Illness_____	Other _____

11. Who is your regular family physician? _____
12. Who or How were you referred to us? _____
13. **FOR FEMALES ONLY:**
    Number of pregnancies_____ Number of children living_____
    Number of children dead_____ Age & Cause of death _____
    Number of miscarriages (abortions) _____
    Date of Last Menstrual period_____
    Date of last pap smear_____ Where was it done? _____
    Are you practicing birth control? Yes No if yes, what type? _____

MEDICINES NOW TAKING (INCLUDING VITAMINS OR SUPPLEMENTS):

_____
_____
_____
_____

LIST ANY ADDITIONAL INFORMATION:_____