



THIS FORM MUST BE COMPLETED PRIOR TO YOUR ARRIVAL AND FAXED TO THE APPROPRIATE LOCATION PROVIDED AT THE BOTTOM OF THE LAST PAGE.

PATIENT MEDICAL HISTORY

Name _____ Date of Birth _____ Age _____

Occupation _____ Appointment Date _____

Main reason for today's visit _____

Which Physician requested this consultation? _____ (First and Last Name)

Pharmacy Name _____ Pharmacy Number _____

Pharmacy Address _____

PERSONAL MEDICAL HISTORY

Do you have or have you ever had any of the following conditions? Please circle.

- Allergies to Environment, Allergies to Food, Anemia, Anesthesia Problems, Asthma, Bleeding Problems, Chicken Pox, Exposure to Tuberculous, Diabetes, Emphysema or COPD, Gastroesophageal Reflux, On C-PAP for Sleep Apnea, Heart Attack, Heart Murmur, Heart Valve Disease, Hiatal Hernia, High Blood Pressure, History of Cancer, History of Kidney Stones, History of MRSA, Jaundice, Liver Infection/Hepatitis, Low Blood Sugar, Malaria, Measles, Mumps, Pneumonia, Rheumatic Fever, Sickle Cell Hb-C Disease, SLE (Lupus), Stroke, Thyroid Problems, No Significant Medical History

OTHER MEDICAL CONDITIONS Do you have any other medical conditions? (If yes please describe below)

PREVIOUS SURGERY List any surgery you have had below (include childhood surgery such as tonsillectomy)

Table with 3 columns: Surgery, Date, Surgeon/Hospital

Name _____ Date of Birth _____ Today's Date _____

MEDICATION

Are you taking any prescribed medicines or over the counter medicines? No Yes (if yes, list below)

Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use any of the following: (please circle any that apply)

Aspirin Ibuprofen Naprosyn Nasal Sprays

How often? _____ Brand name? _____

Are you ALLERGIC to any medications? No Yes (If yes, list below)

Name of medicine	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Do you have a family history of: (immediate family only...parents, siblings)

- Adoption Allergies Asthma Bleeding Problems
- Cancer Foster Care Heart Disease High Blood Pressure
- High Cholesterol Level Stroke Sugar Diabetes Thyroid Cancer
- No Significant History

SOCIAL HISTORY

- A Living Will Non Smoker
- Alcohol abuse Non-drinker
- Alcohol use Pet, cat
- daily _____ Pet, dog
- weekly _____ Smoke exposure
- socially _____ Smoker
- Alcohol, quit _____ Smoker-.05 pack/day
- how many years? _____ Smoker- 1 pack/day
- when did you quit? _____ Smoker- 2 packs/day
- Daycare Smoker- 2+ packs/day
- Daycare not attended Smoker, quit
- No Smoke Exposure how many years _____
- No smoking in the home when did you quit _____
- Amount per day you use to smoke _____

Please check any of the following conditions that apply to the patient:
___ Place a check here if none of the conditions below apply to the patient

Constitution: ___ Chills
Eyes: ___ Double vision
Respiratory: ___ Coughing up blood
GI: ___ Abdominal pain
Breast: ___ Nipple Discharge
GU: ___ Painful Urination
Neurologic: ___ Tremors
Musculoskeletal: ___ Muscle Pain
Endocrine: ___ Excessive Sweating
Psychiatric: ___ Hallucinations

Signature _____
Today's Date _____

Print Name _____
Date of Birth _____

Below is for Office Use only:

I have reviewed the information on this form and found it to be relevant and accurate as of this date.

M.D. _____ Date _____

Indiana Locations
New Albany - State Street
812-945-3557 • Fax 812-949-3599
Jeffersonville
812-206-1910 • Fax 812-206-1941

Kentucky Locations
Dixie Highway Caritas Medical Mall
502-995-5525 • Fax 502-995-5527
Dupont Medical Center
502-893-0159 • Fax 502-213-3853
The Quarry Center - Poplar Level
502-459-3760 • 502-459-3717

Kentucky Locations
LaGrange
502-222-4589 • Fax 502-213-3853
Shelbyville
800-561-2122 • Fax 502-213-3853
Bardstown
800-561-2122 • Fax 502-213-3853