CARE FOR YOU
MEDICAL CENTER
MARGATE

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Date

_____

Chief Complaint

_____

LIST ALL ALLERGIES

_____

LIST ALL PRESCRIBED & NON-PRESCRIBED MEDICATIONS TAKING NOW

_____

MEDICAL HISTORY (Check all that apply)

-

- ☐ Hypertension
- ☐ Diabetes
- ☐ Thyroid
- ☐ Cancer
- ☐ Gastrointestinal Disease

-

- ☐ Heart Disease
- ☐ Neurological Disorder/Disease
- ☐ Urinary Disease
- ☐ Other

If Other, specify

_____

LIST ALL PAST/PRESENT SURGICAL HISTORY

_____

FAMILY HISTORY: (M/MOTHER, F/FATHER, S/SIBLING, B/BOTH) (SELECT WHICH APPLIES)

Hypertension

- ☐ M
- ☐ F
- ☐ S
- ☐ B

Diabetes

- ☐ M
- ☐ F
- ☐ S
- ☐ B

Heart Disease

- ☐ M
- ☐ F
- ☐ S
- ☐ B

Cancer

- ☐ M
- ☐ F
- ☐ S
- ☐ B

Other

- ☐ M
- ☐ F
- ☐ S
- ☐ B

If Other, specify

_____

Number of Pregnancies _____ **Miscarriages** _____ **Abortions** _____

Highest Grade Completed _____ **Patient Employment Status** _____ **Type of Work Perform(ed)** _____

If Not Employed, Last Day of Work _____ **Reason** _____

Patient Smoking Status _____ **Patient Smoking Frequency** _____ **Patient Smoking Start Date** _____

Patient Smoking End Date

Do You Drink?

Yes No

How many?

Do You Use Drugs?

Yes No

How long?

Who Do You Live With?

Are You Right or Left Handed?

Patient/Legal Representative Signature

Date