Hartwell Family Practice

Name_____
DOB_____

Previous Family Physician: _____Phone:_____
Pharmacy:_____Phone:_____

List all medications you are allergic to:
_____
_____
_____

List all Foods you are allergic to:
_____

List anything else you may be allergic to:
_____

Social:
Do you use tobacco? ( ) NO ( ) YES
Type:_____ How long?_____

Do you drink alcohol? ( ) NO ( ) YES
Type:_____ How long?_____

Do you use illegal drugs? ( ) NO ( ) YES
How often? _____ Last Used? _____

Past Medical History:

Surgery	Date

Family Health History: (check all that apply)
( ) Diabetes ( )Cancer ( ) High Blood Pressure

( ) Heart Disease ( ) Tuberculosis ( ) Anemia

( ) Other _____

( ) No significant History

Home Medication: (prescription and nonprescription)

Medication	**Dose**	**Route**	**Frequency**	**Date/time last taken**