



INITIAL POINT FAMILY MEDICINE, PLLC

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Today's Date:

Name:		Reason for today's visit:			
Home phone:	Work Phone:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Race	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Date of Birth:	Current Age:	Religion	Occupation:		
Education					Degree:
Spouse's Name:		Spouse's Occupation:			

PAST MEDICAL HISTORY

SURGERY (type and year)

1.	2.	3.	4.
Other:			

LONGSTANDING MEDICAL PROBLEMS

1.	2.	3.	4.
Other:			

MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING

1.	2.	3.	4.
5.	6.	Other:	

ALLERGIES

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Tobacco:	Type	Amt.	Yrs.	Alcohol:	Beer <input type="checkbox"/>	Wine <input type="checkbox"/>	Liquor <input type="checkbox"/>	Have you ever had:	Y/N	Yr.
Never	Cigarettes			Never	Once a week		<input type="checkbox"/>	Pap Smear?		
Quit	Cigar / Pipe			Quit	2-3 times per week		<input type="checkbox"/>	Mammogram?		
	Smokeless			Rarely	Daily		<input type="checkbox"/>	Tetanus immunization		
					Amount:			Pneumovax?		

FAMILY HISTORY

FAMILY MEMBER NAME	LIVING		DECEASED	
	AGE	HEALTH	AGE	CAUSE
Father				
Mother				
Brothers/Sisters				
Spouse				
Children				

HAVE YOU OR A FAMILY MEMBER EXPERIENCED

	YES	NO	WHO
Allergy / Asthma			
Anemia			
Arthritis / Gout			
Birth Defects			
Bleeding Disorder			
Cancer or Tumor			
Diabetes			
Emphysema			
Epilepsy / Convulsions			
Glaucoma			
Heart Trouble			
Hepatitis / Jaundice			
High Cholesterol			
High Blood Pressure			
Kidney or Bladder Trouble			
Mental Illness or Nervous Breakdown			
Migraine Headaches			
Sexually Transmitted Disease			
Stroke			
Thyroid			
Tuberculosis			
Ulcers			
Other			