Family Healthcare of Lake Norman

Date:

PATIENT INFORMATION

NAME	BIRTH DATE/AGE

FOR OFFICE USE ONLY

EMR _____

Chart No./Room No.

_____

_____

FAMILY HISTORY Please indicate if any of your blood relatives have suffered any of the following. Please indicate FATHER, MOTHER, SISTER, BROTHER, GRANDPARENT, AUNT, UNCLE (paternal/maternal) along with the condition.

1. Epilepsy	8. Diabetes: Type I/Type II	15. Hay fever
2. Osteoporosis	9. Stroke	16. Heart Disease
3. Migraine	10. Hypertension	17. Asthma
4. Arthritis	11. Lipid Disorder	18. Cancer (Please specify)
5. Mental Ill.	12. Thyroid: Hypo/Hyper	19. Anemia
6. Osteo/ Rheumatoid Arthritis	13. Alcoholism	20. Prostate
7. Glaucoma	14. Hepatitis	21. Bleeds easily

PERSONAL OR FAMILY HISTORY REMARKS (Identify Personal History Health Issues)	**DATE OF LAST PHYSICAL**

HOSPITAL ADMISSIONS/SURGERIES (Year/Illness or Operation)

MEDICINES YOU ARE CURRENTLY TAKING	**ALLERGIES** (Medications and Other)

SOCIAL HISTORY	Occupation:		Marital Status: S M W D SEP	
	Alcohol: oz. per day		Coffee/Tea: cups per day	
	Tobacco: cig/day; Years Smoked: Quit -Years Ago:		Exercise: times per week	
OB/GYN HISTORY	Date of Last Pap:	Date of Last Mammogram:	Number of Pregnancies	
	Birth Control Method:	Date of Last Period:	Abortions:	Miscarriages:
	Menstrual Flow: Regular/Heavy	Pain/Cramps	Days of Flow	Length of Cycle / Live Births:

ANY SIGNIFICANT PAST MEDICAL HEALTH PROBLEMS?

REASON FOR TODAY'S VISIT?

An accurate medical history is important for quality medical care. The medical history I am providing on this form is accurate to the best of my knowledge.	Signature:

EXAM (To be completed by medical staff)

Vital Signs	HT	WT(lbs)	BP	PULSE	RESP	TEMP	BMI

Vision	D. Uncor.	D. Cor.	N. UnCor	N. Cor	Color	**Hearing**	500 Hz	1000 Hz	2000 Hz	4000 Hz
Left						**Left** 20/**25**/40dB				
Right						**Right**20/**25**/40dB				

Urinalysis	U.gen	Glu	Ke	Bi	Pr	Ni	Le	Bl	pH	SG

Hb g		**Glu-cose**		**Strep**		**Mono**		**Occult**		**Pulse Ox**		**ECG**		**FLU**		**HC G**	

Physical Exam/Tests/Comments/Plan (No Toradol for Medicare/Tricare due to insurance reimbursement)

Immunization Documentation	VIS Date(s)	Vaccine(s)/Lot/Manufacturer/Exp. Date/Loc.

I have read and understand the Vaccine Information Statement regarding the immunizations I am taking today.	Signature (parent/guardian/patient)