Baptist Health Family Clinic-Hillcrest

2601 Kavanaugh Blvd. Suite 6, Little Rock, AR 72205

Patient Name: _____ DOB:_____ Male or Female

PAST HISTORY: Do you now have or have you ever had any of the following:

Yes	No		Yes	No	
		Diabetes			Cancer (type)
		High Blood Pressure			Tuberculosis
		Heart Disease			Kidney Disease
		Stroke			Anemia
		Asthma			Blood Clot
		Emphysema/COPD			Bleeding Disorder
		Liver Disease			Sexually Transmitted Disease
		Hepatitis			Arthritis
		Ulcers or Reflux			Migraines
		Thyroid Disease			Glaucoma
		Seizures			Depression/Anxiety
		Elevated cholesterol			Fibromyalgia

Other medical problems not mentioned above:_____
_____
_____
_____

You may include additional information on the back of this sheet.

MEDICATIONS: Please list all prescribed drugs and dosages, over-the-counter drugs and herbal medications you are currently taking and state the reason for taking them.

Name of medicine	Dose & Frequency/Time of Day	Reason for Taking

ALLERGIC OR ADVERSE REACTION TO MEDICATIONS:

Name of Medicine	Description of Reaction

Name:_____ DOB:_____

SURGERIES: Please list previous outpatient and major surgeries or serious illnesses requiring hospital stays.

Surgery/Serious Illness	Approx. Year	Hospital/Doctor

FAMILY HISTORY: Are there any family members (parents, grandparents, siblings or children) with:

Condition or Disease	Affected family member(s)
Diabetes	
Heart attack	
Cancer: Type?	
Any other conditions that run in the family	

SOCIAL HISTORY: Who do you live with?_____
Emergency contact: Name:_____ Relation to you: _____
Contact numbers: _____
Which pharmacy do you prefer?_____
Do you have children? Y N If so, what are their names and age_____
Please check one:

[ ] Never smoked cigarettes.
[ ] Former smoker. How many packs per day? _____ For how many years? _____
[ ] Current some day smoker. How many cigarettes per day? _____ For how many years? _____
[ ] Current every day smoker. How many packs per day? _____ For how many years? _____

Do or did you ever smoke cigars, pipes or chew tobacco? Y N Quit? Y N
Do you drink alcohol? Y N How much alcohol do you drink during an average week? _____
Have you quit drinking? Y N If so, when did you quit? _____ How much did you drink per week?_____
Do you now or did you ever use street drugs (LSD, cocaine, marijuana, meth, IV drugs)? Y N Quit? Y N

HEALTH MAINTENANCE: Please indicate whether you have had the following screening tests and/or immunizations and the approximate date the most recent test or immunization was done.

Screening Test	Y	N	Approx. date last performed
Pap Smear			
Mammogram			
Bone density test			
Colonoscopy			
PSA (prostate lab test)			

AUTHORIZATION AND RELEASE:
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical history. I also authorize the healthcare staff to perform the necessary services I may need.

X_____ Date: _____
Signature of patient or parent if minor