Lakeshore Health Partners
A Holland Hospital Physician Office

Name:_____ Date:_____

Occupation:_____ Date of Birth:_____

CONFIDENTIAL INFORMATION: Information contained here will not be released except when you have authorized in writing for us to do so.

Please describe your present medical concerns:

_____

_____

_____

_____

FAMILY HISTORY

	Print Name	Gender	Age	Health	Cause of Death
Father					
Mother					
Brother					
Sister					
Spouse					
Children					

ADDITIONAL ILLNESSES OR PROBLEMS

Check the appropriate boxes and place the familial relationship in the space provided. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

	Glaucoma:		Arthritis:		Anemia:		Thyroid Disease:
	Leukemia:		Epilepsy:		Eczema:		Anxiety:
	Hay Fever:		Depression:		Hypertension:		Colitis:
	Bronchitis:		Suicide:		Heart Disease:		Emphysema:
	Balloon Dilitation:		Pneumonia:		Kidney:		Angina:
	Tuberculosis:		Gout:		Heart Bypass:		Liver Disease (Hepatitis)
	Jaundice:		Stroke:		Diabetes:		Migraine:
	Bleeding:		Stomach Ulcers:		Asthma:		
	Heart Attack (list age at time):				Cancer (list location and age):		
	Osteoporosis (weak bones):				Spinal vertebrae fractures:		
	Blood clots:				Hip fractures:		

Personal Habits: (circle)

Yes No Have you ever smoked? ___Cigarettes ___Pipe ___Cigars How many years?_____

Yes No Do you usually drink over 2 cups of coffee per day? How many do you drink?_____

Yes No Do you drink other caffeine containing products? If so, what do you drink?_____
How many glasses do you drink a day?_____

Yes No Do you regularly drink alcohol? ___1 oz/day ___2 oz/day ___4 oz/day ___over 6 oz/day
BEER:_____1 bottle/day _____2 bottles/day _____over 4 bottles/day

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MEDICATIONS

Please list all of the medications that you are currently taking. Please continue on back if needed.

Name of Medicine	Dosage	Number of times a day	Name of Medicine	Dosage	Number of times a day

Are you currently taking any of the following medications? (circle)

Y	N	Aspirin, Bufferin, Motrin	Y	N	Laxatives	Y	N	Shots
Y	N	Blood pressure pills	Y	N	Sleeping pills	Y	N	Water Pills
Y	N	Cortisone	Y	N	Thyroid Medicine	Y	N	Antibiotics
Y	N	Cough Medicine	Y	N	Hormones	Y	N	Barbiturates
Y	N	Digitalis	Y	N	Supplements/vitamins	Y	N	Birth Control Pills
Y	N	Ibuprofen (Advil, Motrin, Nuprin)	Y	N	Tranquilizers	Y	N	Phenobarbital
Y	N	Insulin or diabetic pills	Y	N	Weight reduction pills	Y	N	Acetaminophen
Y	N	Iron or 'poor blood' medications	Y	N	Blood thinning pills	Y	N	Inhalers
Y	N	Other Drugs Not Listed	Y	N	Dilantin	Y	N	

Name any drugs to which you are allergic and type of reaction?_____

_____

_____

PAST SURGICAL HISTORY

(including cataracts, colonoscopies/sigmoidoscopies)

TYPE OF SURGERY	DATE OF SURGERY (YEAR)	SURGEON

PAST MEDICAL PROBLEMS – CHILDHOOD ILLNESSES

		ILLNESS	AGE			ILLNESS	AGE			ILLNESS	AGE
Y	N	Chicken Pox		Y	N	Measles		Y	N	Rheumatic Fever	
Y	N	Mumps		Y	N	Scarlet Fever		Y	N	Polio	

OTHER MEDICAL PROBLEMS requiring hospitalization or extensive medical care:

_____

_____

ACCIDENTS AND INJURIES INCLUDING FRACTURES AND JOINT INJURIES:

_____

_____

IMMUNIZATIONS

	Date of Primary Series	Date of Latest Booster	Other Immunizations	Date Given
Tetanus				
Pneumovax				
Polio				
Hepatitis B				
Measles, Mumps, Rubella				

List any questions you have for the doctor:

_____

_____

_____