PREADMISSION DATA

FRAN-255-6781 EXTENSION: 126
255-6251
PLEASE BRING ALL YOUR MEDICATIONS WITH YOU ON YOUR H&P APPOINTMENT

H&P APPOINTMENT DATE _____
DOCTORS OFFICE FIRST THEN PRE-TESTING AT HOSPITAL

PLEASE FILL OUT BOTH SIDES OF THIS FORM IN DETAIL AND BRING WITH YOU FOR THE ABOVE APPOINTMENT

NAME _____

AGE _____ MARITAL STATUS M___ S___ D___

Occupation _____
(if retired, please give previous occupation)

PAST MEDICAL HISTORY
Name of family physician _____

Last Visit _____

Previous serious illness _____

_____

Any serious injuries not requiring hospitalization: _____

The following will be filled out in the office:

Type of Surgery: _____

Date of Surgery: _____

Admitting Physician: _____

Hospital _____ IP OP 23 obs. CASE# _____

Other scheduled cases:
1. _____
2. _____
3. _____
4. _____

HOSPITALIZATIONS: (Include all since childhood: females, include child birth)

YEAR	REASON	HOSPITAL	YEAR	REASON	HOSPITAL

MEDICATIONS: (Please list all medications you are taking at this time, including aspirin; if unsure of medications, bring it with you!)

MEDICATION	SIZE (MG)	HOW OFTEN	MEDICATION	SIZE (MG)	HOW OFTEN

Allergies: (List all allergies to medications, tapes, iodine and foods)

_____

_____

SOCIAL HISTORY:

Are you on a restricted diet? Yes_____No_____
Do you now smoke or have you smoked in the past? Yes_____ No_____ Year Quit_____
If YES, how many packs per day? _____; How many years_____
Do you chew tobacco? Yes_____ No_____
Do you drink alcohol? (circle one) NEVER RARELY SOCIAL MODERATELY EXCESSIVELY
Do you have a Drug/Substance abuse problem? Yes_____ No_____
Have you been treated for Drug/Substance/Alcohol abuse problem? Yes_____ No_____

FEMALES: Date of last menstrual period:_____ Last gynecological exam:_____
Have you ever been pregnant? Yes_____ No_____

FAMILY HISTORY: (DO ANY OF YOUR BLOOD RELATIVES HAVE OR HAD THE FOLLOWING CONDITIONS; IF YES, Please state relationship directly after each on the blank.)

Heart Disease	YES	NO	_____	Kidney Disease	YES	NO	_____
Heart Attack	YES	NO	_____	Thyroid Disease	YES	NO	_____
Seizures	YES	NO	_____	Arthritis	YES	NO	_____
Strokes	YES	NO	_____	Cancer (give type)	YES	NO	_____
Hypertension	YES	NO	_____				_____
Diabetes (sugar)	YES	NO	_____	Bleeding Disorder	YES	NO	_____

REVIEW OF SYSTEMS: (Circle Y for YES or N for NO ... Answer Every question)
Have you ever had or are presently being treated for any of the following conditions:

Y	N	BLURRED VISION	Y	N	ULCERS
Y	N	SEEING DOUBLE	Y	N	KIDNEY PROBLEMS
Y	N	WEAR CONTACT LENS	Y	N	KIDNEY STONES
Y	N	DIFFICULTY IN SWALLOWING	Y	N	KIDNEY INFECTION
Y	N	HOARSENESS	Y	N	BURNING WITH URINATION
Y	N	RECENT VOICE CHANGE	Y	N	BLOOD IN URINE
Y	N	DO YOU WEAR DENTURES			
Y	N	RHEUMATIC FEVER	Y	N	FREQUENT NIGHT URINATION
Y	N	SCARLET FEVER	Y	N	URINATE FREQUENTLY
Y	N	SINUSITIS	Y	N	SEIZURES
Y	N	HAY FEVER	Y	N	DIZZINESS
Y	N	WHOOPING COUGH	Y	N	HEADACHE
Y	N	SHORTNESS OF BREATH	Y	N	LOSS OF CONSCIOUSNESS
Y	N	FREQUENT COUGH	Y	N	PARALYSIS
Y	N	COUGH UP BLOOD	Y	N	COMA
Y	N	PNEUMONIA	Y	N	SUGAR (DIABETES)
Y	N	BRONCHITIS	Y	N	ASTHMA
Y	N	TUBERCULOSIS			
Y	N	PLEURISY	Y	N	THYROID DISORDERS
Y	N	CHEST PAIN	Y	N	ANEMIA (LOW BLOOD)
Y	N	HEART ATTACK	Y	N	EASY BRUISING
Y	N	HEART DISEASE	Y	N	FREQUENT NOSE BLEEDS
Y	N	STROKES	Y	N	CANCER (GIVE TYPE)
Y	N	HIGH BLOOD PRESSURE	Y	N	ARTHRITIS
Y	N	NAUSEA OR VOMITING	Y	N	CHANGE IN WEIGHT
Y	N	VOMIT BLOOD	Y	N	FEVERS
Y	N	DIARRHEA	Y	N	SHAKES OR CHILLS
Y	N	CONSTIPATION	Y	N	BLOOD IN STOOLS
Y	N	BLACK TARRY STOOLS	Y	N	JAUNDICE (TURN YELLOW)
Y	N	HEPATITIS	Y	N	FOOD INTOLERANCE

DO NOT WRITE BELOW THIS SPACE

HPI:	CNS:	PE:	LUNGS:
		GEN:	CARDIAC:
		HEENT:	PULSES:
		NECK:	GI:
		CHEST:	GU: