ASHLEY RIVER FAMILY PHYSICIANS
ROPER ST. FRANCIS PHYSICIANS

Patient Name: _____

List ALL current **Medications** (Include any over the counter medicines, vitamins or supplements): **{ } NO Medicines**

Name of medication	Strength	Times a day	Dr. who prescribed

Pharmacies:

Local or Mail Order?	Preferred Pharmacy	Street / City	Phone #

Do you have any **ALLERGIES** to Medicines? Yes/ No Food? Yes / No Environmental? Yes / No

Name of Allergen	Type of Reaction	Name of Allergen	Type of Reaction

List any **chronic medical conditions** you are being treated for: **{ } No Chronic conditions**

Problem or diagnosis	Date diagnosed	Doctor who treats you (if not us)

List any **surgeries** you have had: **{ } No Surgeries**

Type / name of surgery	Date (month / year)	Doctor who preformed

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Patient Name: _____

Hospitalizations: { } **No Hospitalizations**

Reason	Date (month / year)	Doctor

List any **Medical Problems** or Diseases you have had in the past (not listed previously)

Problem or diagnosis	Date diagnosed	Doctor who treated you (if not us)

Family History List any diseases or problems your family members have. Ie. Cancer, Stroke…

	Alive/Deceased	Medical Problem(s) / Diseases / Cause of Death
Father		
Mother		
Sister(s)		
Brother(s)		
Daughter(s)		
Son(s)		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Aunt		
Uncle		

	Date last done	Doctor	Normal / Abnormal ?
Colonoscopy			
Mammogram			
Bone Density			
Pap Smear			
PSA			
Eye Exam			
Tetanus Shot			N/ A
Pneumonia Shot			N/ A

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Patient Name: _____
Date of Birth: _____

Social History:

Highest level of Education: _____ Occupation: _____ # years: _____
[ ] full time [ ] part time [ ] retired [ ] unemployed [ ] Going to school

Children # sons _____ # daughters _____ Pets? _____

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed # years _____
If not married, do you have a significant other? _____ # years _____

Do you have any aids such as a walker, cane, hearing aids, etc? _____

Religion: _____ Other special needs? _____

Exercise: [ ] None [ ] Occasionally [ ] _____ times a week Type of exercise _____

Tobacco / Nicotine Use [ ] Never Smoked or used tobacco [ ] **Quit** Date: _____

How many a day? _____ How soon after you wake up? _____ Are you interested in quitting? ____

Alcohol Use:
[ ] Never use Alcohol [ ] History of alcohol dependency Date quit _____

Did you have an alcoholic drink in the last year?
How often did you have an alcoholic drink in the last year? _____
How many drinks did you have on a typical day in the last year? _____
Have you had 6 or more drinks on one occasion in the last year? _____

Caffeine: [ ] coffee [ ] tea [ ] soda [ ] other _____ Amount _____ per _____

Breathing (COPD Screen):

During the last 4 weeks, how much time did you feel short of breath?
[ ] None [ ] a little of the time [ ] some of the time [ ] most of the time [ ] all of the time
+ ++ ++
Do you ever cough up any "stuff", such as mucus or phlegm?
[ ] no, never [ ] only with colds [ ] yes, a few days a month [ ] yes most days a week [ ] Yes every day
+ + ++
I do less than I used to because of my breathing problems in the last 12 months?
[ ] No [ ] unsure [ ] Yes [ ] Yes, it's a problem
+ ++
Have you ever smoked more than 100 cigarettes in your entire life? [ ] Yes [ ] No
++
How old are you? [ ] 35-49 [ ] 50-59 [ ] 60-69 [ ] 70+
+ ++ ++

Signature _____ Date: _____