North Main Medical

3094 North Main Street Crossville, Tennessee Phone: (931) 644-5423 Fax: (931) 337-0155

Date: ______________________

Medical History

Name: ____

Date of Birth: _________________

Physician Name: ___________________________________

Pharmacy: ______________________________

Dentist: ____

Date of Last Visit: ________________________

Occupation:

____

Main reason for today's visit?

____

Is this a worker's compensation injury? Yes No

Medications: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medications (include type of reaction): ______________________
____
____

Medical Problems: Have you had (or do you have) any of the following medical problems (please circle):

High Blood Pressure	Cancer	Asthma	Lung Disease
Abnormal PAP Smear	Heart Disease	Arthritis	Urinary Tract Infection
Heart Attack	Tuberculosis	Seizure Disorder	Liver Disease/Hepatitis
Pancreas Disorder	Stroke	Sickle Cell	Blood Transfusion
Diabetes	Anemia	STDs	Thyroid Disease
Kidney Disease	HIV/AIDS	Skin cancer	Other: ________________________

List any major injuries/surgeries the patient has had in the last five (5) years:

____
____
____

List any recent hospitalizations:
____

If applicable complete this section:

Female: Total pregnancies: ___ # Live births: ____ # Miscarriages: ____
Last Menstrual Period: ___________________
How old were you when you had first menstrual period? _________________
What type of birth control do you use? _________________________________
When was your last mammogram? ____________________________________
Have you ever had an abnormal mammogram? _________________________
When was your last PAP Smear? ______________________________________
Have you ever had an abnormal PAP Smear? ___________________________
Is there any possibility you are pregnant? _____________________________

Male: Last PSA: ________________ Prostate Exam: __________________

Patient Social History: (Please circle all that apply.)

Use of Alcohol: Never Rarely Moderate Daily Previously, but quit _____ years.
Use of Tobacco: Never Rarely Moderate Daily Previously, but quit _____ years.
Current: ____ packs a day for ______ years.
Use of drugs: Never
Type: Frequency:

Excessive Exposure at Home or Work to (please circle):

Fumes Air-borne particles
Dust Noise
Solvent

Family Medical History: Have any immediate/close family had (or currently have) any of the following medical problems (please circle):

Heart Disease Cancer Asthma
High Blood Pressure Stroke Severe Allergies
Diabetes Thyroid Disease

Immunizations: Have you had any of the following immunizations (please circle):

Influenza Pneumonia Varicella Shingles
MMR Polio DPT Hepatitis

For children **ONLY**:

What school/daycare does the child attend? ____

Has your child experienced any emotional, physical, and/or social problems at school/daycare?
Yes No
If yes, please explain: ____

To the best of my knowledge, my child is up to date on his/her immunizations. Yes No

Is the child cared for by anyone other than the parent? Yes No
If yes, whom? ____

Does anyone in your home smoke? Yes No