the memorial hospital at craig

______________________________ Name

______________________________ Date

______	______	______	______	____/____	______	______	______________________
HT	WT	Temp	HR	BP	O2	RR	Allergies

PAST MEDICAL HISTORY

PLEASE CIRCLE ANY THAT APPLY

Seasonal Allergies
Alcoholism
Alzheimer's
Arthritis
Asthma
Anxiety
Depression
Atrial Fibrillation
Low Back Pain
Cancer ____________________
Congestive Heart Failure
Coronary Artery Disease
Dementia
Diabetes
Dyspepsia
DVT
Pulmonary Embolism
Gastroesophagil Reflux Disease
Glaucoma
Gout
High Blood Pressure
High Cholesterol
Migraine
Multiple Sclerosis
Oesteoarthritis
Seizure Disorder
Stroke
Thyroid Condition
Parkinson's
Other _____________________
No Significant History

SURGERIES

PLEASE CIRCLE ANY THAT APPLY

Ankle/Hip
Appendectomy
Back Surgery
Carpal Tunnel
Cataract Extraction
Gall Bladder
Heart
Hernia
Lasix
Knee
Mastectomy
Thyroidectomy
Tonsillectomy
Tubal Ligation/Hysterectomy
Vasectomy
Other ___________________

FAMILY HISTORY

Alcoholism
Alzheimer's
Depression
Anxiety
Diabetes
Glaucoma
Heart Disease
High Blood Pressure
Headaches
High Cholesterol
Multiple Sclerosis
Parkinson's
Seizures
Stroke
Cancer ____________________
Other _____________________
No Significant History

SOCIAL HISTORY

PLEASE CIRCLE ANY THAT APPLY

Marital Status M / D / S / W
Regular Exercise Y / N
Have you ever used tobacco Y / N
Currently Use _____ Pks/Day
Recreational Drug Use Y / N
DO YOU WANT TO QUIT? Y / N
Alcohol Rare/Social/Daily ___day
Caffeine None/Rare/Morning ___day
Occupation ________________
Sleep Habits Well/Restless/Snore
Birth Control Pill/IUD/Tubaligation
Vasectomy
DNR/Living Will - Yes / No
Stressors- _________________
What Pharmacy do you use?
____

GENERAL HEALTH YEAR

GENERAL HEALTH	YEAR
Tetnus	________
Flu Vac	________
Pneumo	________
Cholesterol	________
Prostate	________
PAP	________
Rectal	________
Mammogram	________

BODY SYSTEMS

Fatigue/Insomnia
Weight Changes
Chest Pain
Heart Burn
Depression
Menstrual Problem/Pregnant
Shortness of Breath
Urinary/Bowel Change
Headaches
Other: ___________________

CHIEF COMPLAINT:

____
____
____

CURRENT MEDICATION: Please list any/all medications

____

____