Mercy

Your life is our life's work.

Patient Name: _____**DOB:** _____ **Sex:** _____

Allergies: _____

Primary Care Provider: _____

Medications: (Include over the counter medications that you use)

_____ _____

_____ _____

_____ _____

_____ _____

Medical History:

Previous Surgeries: No Yes If yes, what type/when?: _____

Previous Hospitalizations: No Yes If yes, what type/when?: _____

Headaches/Migraines	No Yes	Environmental/Seasonal Allergies	No Yes
Diabetes	No Yes	High Cholesterol	No Yes
High Blood Pressure	No Yes	Cancer	No Yes
Seizures	No Yes	Anxiety	No Yes
Depression	No Yes	Asthma/Breathing Problems	No Yes
Blood/Immune System Problems	No Yes	Heart Problems	No Yes
Liver or Kidney disease	No Yes	Thyroid Problems	No Yes

Are you currently under a physician, specialist, or other healthcare providers care for any problems?

If yes, please include provider and brief explanation: _____

Are there any other mental or physical conditions we should know about?

_____

Social History:

Cigarette Smoking: Never Previous, but quit When? _____ Current packs per day _____

Vaping or any other Tobacco products (including chew): Never Previous, but quit When? _____

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Alcohol use: Never Rarely Moderate Daily _____ (Number of drinks per day)

Recreational or Medicinal Drug use: Never Yes Type and Frequency _____

Family History:

Father: Alive Deceased Diseases_____

Mother: Alive Deceased Diseases_____

Siblings: Alive Deceased Diseases_____

Children: _____

Currently Pregnant/Breastfeeding? No Yes