WASHINGTON HEALTH SYSTEM
Family Medicine - North Main

Patient Information

Name____DOB____________
Address_________________________City_____________State_________Zip______
Circle Payment Type: Insurance / Self Pay
Emergency Contact:___________________Phone_________Relationship___________

If Patient is a Minor

Mother's Full Name_________________ Father's Full Name ____________________
Legal Guardian's Full Name (if not mother or father) ____________________________
Primary Insurance Holder for Patient____

Allergies: ____

Medications: *List prescriptions, over the counter medications and vitamins*

____________________	_______________________	_____________________
____________________	_______________________	_____________________
____________________	_______________________	_____________________
____________________	_______________________	_____________________
____________________	_______________________	_____________________

Pharmacy: ____

Social History:

Smoke YES NO	If yes, # packs/day____________	For how many years?_______
Exercise YES NO	If yes, mild intensity___________	Moderate Intensity ________
Alcohol Use YES NO	How often___________________	How many_________________
Drug Use YES NO	If yes, type _________________	How often________________

Hospitalizations:

Reason	*Date*
____	_____________
____	_____________
____	_____________
____	_____________

Surgeries:

Reason	*Date*
____	_____________
____	_____________
____	_____________
____	_____________

Past Medical History: *Circle all that apply.*

Abnormal Pap Smear
Allergic Rhinitis (Nasal Allergies)
Alcohol abuse
Anemia
Anxiety
Asthma
Atrial Fibrillation
BPH (Enlarged Prostate)
Bronchitis – Chronic
Cancer
Cardiomyopathy
Colon Polyps
COPD (Lung Disease)
Coronary Artery Disease (Heart Disease)
CVA (Stroke)
Dementia
Depression
Diabetes (Insulin Dependent)
Diabetes (Non Insulin Dependent)
Drug Abuse
Emphysema
GERD (Heartburn)
Glaucoma
Gout
Headaches (Migraine)
Hepatitis
Hyperlipidemia (High Cholesterol)
Hypertension (High Blood Pressure)
Hypothyroidism
Irritable Bowel Syndrome
Kidney Disease
Lumbar Stenosis
Menopausal Symptoms
Osteoarthritis
Osteopenia
Osteoporosis
Palpitations
Peptic Ulcer Disease
PVD (Vascular Disease)
Rheumatoid Arthritis
RLS (Restless Leg Syndrome)
Sexually Transmitted Disease
Sleep Apnea
Tuberculosis

Other:
____
____
____
____

Family Medical History: *For each of the relatives listed below, please list any of the following illnesses that apply.*

Relative — *Illness (example: Cancer, High Blood Pressure, Heart Disease, Diabetes, Stroke, Depression, Anxiety, Glaucoma, Alcohol or Drug Abuse, other)*

Relative	Illness
Father	
Mother	
Sister	
Brother	
Son	
Daughter	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Aunt / Uncle	
Other	

***If family history is unknown, please check "Medical History Unknown"*

_____ Medical History Unknown