GREYSTONE MEDICAL CLINIC

PATIENT'S PERSONAL / FAMILY HISTORY INFORMATION

Last Name:	First Name:	Middle Initial:	Gender:

D/O/B:	Race:	Married □ Single □ Widow(er) □ Divorced □

Occupation? **Referred by?**

Symptoms: Check (√) Symptoms you currently have now or have had in the past year.

GENERAL: □ Fever □ Chills □ Decreased Appetite □ Fatigue □ Night Sweats □ Insomnia □ Hives

HEAD: □ Trauma □ Headaches / Migraines □ Dizziness

EARS: □ Hearing Changes □ Ringing in Ears □ General Pain □ Discharge □ Vertigo

EYES: □ Vision Changes □ Sensitivity to Light □ Blurred Vision □ Double Vision □ Drainage

NOSE: □ Sinus Congestion □ Nose Bleeds □ Polyps

THROAT: □ Hoarseness □ Sore Throat □ Tooth Loss

CHEST: □ Cough □ Shortness of Breath □ Pneumonia □ Wheezing □ Coughing up Blood

CARDIAC: □ Chest Pain □ Shortness of Breath □ Palpitations □ Edema

ABDOMEN: □ Heartburn □ Nausea □ Vomiting □ Indigestion □ Diarrhea □ Constipation

URINARY TRACT: □ Urgency □ Frequency □ Hesitancy □ Blood in Urine □ Incontinence

NEUROLOGICAL: □ Tremors □ Fainting □ Seizures □ Numbness □ Tingling □ Confusion

PSYCHOLOGICAL: □ Depression □ Anxiety □ Suicidal thoughts

MUSCULOSKELETAL: □ Arthritis □ Trauma □ Joint Swelling

ENDOCRINE: □Excessive Thirst □ Hot/Cold Intolerance □ Irregular periods □ Change in Skin Pigmentation

Condition(s)- Present & Past: Check (√) Conditions you have or have had in the past year

□ Anemia	□ Chicken Pox	□ Migraine headaches
□ Anorexia	□ Depression	□ Multiple Sclerosis
□ Appendicitis	□ Diabetes	□ Pneumonia
□ Arthritis	□ Emphysema	□ Stroke
□ Asthma	□ Epilepsy	□ Thyroid Problems
□ Back pain/injury	□ Glaucoma	□ Tonsillitis
□ Bleeding disorder	□ Gout	□ Tuberculosis
□ Breast lump	□ Heart disease	□ Venereal disease
□ Bronchitis	□ Hepatitis	□ Other:
□ Cancer	□ Hernia	
□ Cataracts	□ High Cholesterol	

Family History

	Family Members:							
Illness/Condition	Mother	Father	Grandma	Grandpa	Sibling	Daughter	Son	Other
Asthma								
Bleeding Disorder								
Cancer								
Diabetes								
Glaucoma								
Heart disease								
High Blood Pressure								
Depression								
Lung Disease								
Thyroid Disease								

Prescribed Medication(s)

Prescription Medications	Dosage / Milligrams	How are the Meds Taken?

Non-Prescription Medications

Over the Counter Medications / Vitamins / Supplements:	Dosage / Milligrams	How are the Meds Taken?

Surgeries

Year	Surgical Procedure	Reason

Other Illnesses /Accidents: Include Car/Motorcycle/4-Wheeler, Etc.

Year	Serious Illness/Injury/Accident	Outcome

Allergies or Drug Reactions? Please List Drug / Type of Reaction

Past / Current Habits

Do you smoke? □ Yes □ No If yes, how many packs per day? If quit, how long ago?

Do you use alcohol? □ Yes □ No If yes, how often do you drink?

Acknowledgement

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of Patient / Guardian **Date**