Emmason Pediatric and Family Clinic

General Health Information Form

Reason for your Visit: ____

Name: ____ Date of Birth: _______________

Occupation: ____ Sex: (circle one) FEMALE MALE

Education: (Check highest) ELEMENTARY HIGH SCHOOL COLLEGE POST GRAD

Current Medication: __________________________________ Allergies: ___________________________

____ ___________________________________

____ Surgeries: ____________________________

____ ___________________________________

Current Medical Problems:

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Family Medical Problems:

Mother: _________________________

Father: __________________________

Brother: _________________________

Sister: __________________________

Marital Status: S__ M__ D__ W__

Do You:

Smoke? ____________ Amount: ________________ (Day / Week) How Many Years? __________________

Tobacco? ___________ Amount: ________________ (Day / Week) How many Years? __________________

Alcohol? ________________________________ Quantity: __________________________ per Day / Week?

Nutrition Supplements? __________________ Type: ____

Recreational Drugs? ______________________ Type: ____

Have You Had Recent (give year): Diphtheria/Tetanus __________ FLU VACC: _________ Pneumonia VACC: ______

FEMALES: LMP__________________ Number Of Pregnancies: _______________ Miscarriages: __________

Circle All That Apply:

Headaches	Chest Pains	Enlarged Vein	Changes in stool size
Fainting	High blood pressure	Heart Burn	Colitis
Dizziness	Stroke	Nausea/Vomiting	Gout
Blurred Vision	Heart Murmur	Diarrhea	Fractures
Double vision	Short of Breath	Blood in stool	Glaucoma
Eye Pain	Tuberculosis	Anemia	Cataracts
Ear Ache	pneumonia	Painful Urination	Asthma
Hearing Loss	Hay Fever	Blood in Urine	Penile Discharge
Heart Bypass	Cancer	Cough	Leg pains
Sore Throat	Palpitations	Vaginal Discharge	Arthritis
Bleeding gums	Swollen Feet	Loss of Urine/Feces	Seizures
Nose Bleeds	Abdominal pain	Skin Changes	Asthma

Other (please explain): ____

Signature: ____ Date: ______________________________