

Health Assessment

Ardmore Family Practice, PA

IDENTIFICATION DATA

Today's Date _____

Full Name _____ Male () Female ()
Street _____ Single () Divorced () Separated ()
City _____ State _____ Zip _____ Married () Widowed ()
SS# _____ Date of birth _____ Employer _____
Home phone _____ Work phone _____ How did you hear about us? _____ Family _____ Friends
_____ Advertisement _____ Phone Book _____ Insurance
Mother's full name _____

What pharmacy do you use? _____

PRESENT ILLNESSES: (Please list health problems which concern you or problems for which you are being treated)

1 _____ 3 _____

2 _____ 4 _____

ALLERGIES: (Include bad reactions to medicines, foods, and environmental factors such as smoke or pollen)

1 _____ 3 _____

2 _____ 4 _____

MEDICATIONS: (List all medicines taken on a regular basis, including birth control pills, herbal products, and over-the-counter products)

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

PAST MEDICAL HISTORY: (List all hospitalizations, surgeries, and serious medical problems you have had such as increased blood pressure, heart disease, elevated cholesterol, diabetes, cancer, etc.)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

FOR WOMEN: List dates of any pregnancy and outcome:
