WADDELL
FAMILY MEDICINE
Specializing in YOU!

PATIENT HEALTH HISTORY
WADDELL FAMILY MEDICINE

NAME:_____ BIRTH DATE: _____ TODAY'S DATE:_____

HEIGHT:_____WEIGHT:_____ALLERGIES:_____

MEDICAL PROBLEMS: _____
_____
_____

MEDICATIONS AND DOSE: _____
_____
_____

SURGERIES: _____
_____
_____

SOCIAL HISTORY

OCCUPATION: _____

TOBACCO USE: ____PKS PER DAY X____YEARS HAVE YOU EVER QUIT? Y/N

HOW LONG AND HOW DID YOU DO IT? _____
ALCOHOL: ____DRINKS PER_ DAY/WEEK/MONTH/WEEKEND (CIRCLE_ONE) _____

EXERCISE: (WHAT KIND AND HOW OFTEN?)_____
_____

FAMILY MEDICAL HISTORY: (LIST MEDICAL PROBLEMS, NOT NAMES)

MOTHER: _____

MAT. GRANDMOTHER_____MAT. GRANDFATHER_____

FATHER: _____

PAT. GRANDMOTHER_____PAT. GRANDFATHER_____

SIBLINGS: #SISTERS_____#BROTHERS_____LIST ANY MEDICAL PROBLEMS: _____
_____

CHILDREN (LIST AGES/GENDER & ANY MEDICAL PROBLEMS):_____
_____
_____

LAST TETANUS BOOSTER: _____ HAVE YOU HAD CHICKENPOX DISEASE/VACCINE?_____

HAVE YOU HAD HEPATITIS B, HPV, OR SHINGLES VACCINE? _____

DO YOU HAVE A LIVING WILL/ADVANCE DIRECTIVE? _____ IF NOT, WOULD YOU LIKE INFO?_____

_____
_____
_____