Entira® FAMILY CLINICS
Where generations thrive®

NEW PATIENTS – PLEASE FILL OUT COMPLETE FORM
ESTABLISHED PATIENTS – PLEASE WRITE IN ALL MEDICATIONS AND ALLERGIES
HISTORY SECTIONS PLEASE ONLY UPDATE SINCE YOUR LAST PHYSICAL EXAM

NAME_____ **NICK NAME** _____

BIRTHDATE_____ **TODAY'S DATE**_____

CURRENT MEDICATIONS:

MEDICATION	DOSE	# OF TIMES PER DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PLEASE LIST ANY MEDICAL CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH:

NEW PATIENTS – PLEASE COMPLETE
ESTABLISHED PATIENTS- SINCE YOUR LAST ANNUAL EXAM/PHYSICAL

1._____
2._____
3._____
4._____
5._____

DRUG ALLERGIES/DRUG SENSITIVITIES

MEDICATION	REACTION
1.	
2.	
3.	
4.	
5.	

PAST SURGERIES:

NEW PATIENTS – PLEASE COMPLETE

ESTABLISHED PATIENTS – SINCE YOUR LAST ANNUAL EXAM / PHYSICAL

DATE	SURGERY
1.	
2.	
3.	
4.	
5.	

PAST HOSPITALIZATIONS:

NEW PATIENTS – PLEASE COMPLETE

ESTABLISHED PATIENTS – SINCE YOUR LAST ANNUAL EXAM / PHYSICAL

DATE	REASON
1.	
2.	
3.	
4.	
5.	
6.	

FAMILY HISTORY:

Paternal = Father's side, Maternal = Mother's side

NEW PATIENTS – PLEASE COMPLETE

ESTABLISHED PATIENTS – SINCE YOUR LAST ANNUAL EXAM / PHYSICAL

	Alive/Deceased	Age	Health problems
Father			
Mother			
Siblings			
Children			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			
Paternal uncles			
Paternal aunts			
Maternal uncles			
Maternal aunts			
Other			

ANESTHESIA REACTIONS: Y / N
BLEEDING PROBLEMS: Y / N
LIVING WILL: Y / N

SOCIAL HISTORY:

NEW PATIENTS – PLEASE COMPLETE
ESTABLISHED PATIENTS – SINCE YOUR LAST ANNUAL EXAM / PHYSICAL

Tobacco use: Y / N

How many years _____ how many packs/day _____

Occupation? _____ Full time / Part time

Married / Single / Widowed / Divorced

Are you around secondhand smoke? Y / N

What is your highest level of education? _____

Who do you live with? _____

Do you drink alcohol? Y / N How often?_____

Do you use any recreational drugs? Y / N

What are your hobbies? _____

Do you exercise? Y / N How often? _____

Do you have any pets? _____

Are you sexually active? Y / N

Do you wear your seatbelt? Y / N

Do you feel safe at home? Y / N

Do you drink caffeine? Y / N

What is your religion? _____

Do you have any guns in the home? Y / N

What is your primary language? _____

Do your smoke detectors work? Y / N

What is your ethnicity? _____

Do you have any financial concerns? Y / N

Have you traveled outside the U.S. in the past year? Y / N