PARIS FAMILY PHYSICIANS P. A.

DATE: _____ PHYSICIAN and/or NP: _____

Legal name _____ Any other names used _____

Date of birth _____

Past Operations/hospitalizations/medical illnesses _____

_____

Family history (Diabetes, hypertension, heart or kidney trouble, cancer or tuberculosis) _____

_____

Childbirths and/or miscarriages _____

Blood Transfusions: Yes____ No ____

Habits: Tobacco Yes ____ No ____ Alcohol Yes ____ No ____ Street Drugs: Yes ____ No ____

If yes, how much _____ how long _____

ALLERGIES TO MEDICATIONS _____

_____

Have you had problems with:	**No**	**Yes**
Anemia		
Appendicitis		
Arthritis, rheumatism		
Asthma		
Back trouble		
Bronchitis, emphysema		
Cancer		
Convulsions, seizures, epilepsy		
Chronic cough		
Persistent cough		
Diabetes		
Frequent vomiting		
Gallbladder trouble		
Goiter, thyroid trouble		
Hay fever		
Headaches, frequent or severe		
Hemorrhoids		
Hernia		
Heart trouble		
High blood pressure		

Have you had problems with:	**No**	**Yes**
Nervous disorder or mental illness		
Night Sweats		
Pleurisy or other chest pain		
Pneumonia		
Prostate or kidney trouble		
Frequent rashes		
Rectal bleeding		
Rheumatic fever		
Sinus infection		
Stomach ulcer/reflux		
Strokes		
Tonsillitis		
Trouble breathing		
Trouble with periods		
Tuberculosis		
Varicose veins		
Vertigo, dizzy spells		
Wheezing		
Yellow jaundice, hepatitis		
Elevated cholesterol		

If any answer to any of the above is yes, please explain:

_____

_____ Please use back of form if additional space is needed.