BELLBROOK FAMILY PRACTICE MEDICAL PROFILE

Name ______________________________ Date ______________
Date of Birth ____________ Age ________ Sex: M F Marital Status: S M D W
Your pharmacy ______________________________

Past Medical History

Illnesses: check any of the following that you have been treated for:

High Blood Pressure ______	Fibromyalgia ______	Osteoporosis ______
Stroke ______	Headaches ______	High Cholesterol ______
Coronary Artery Disease ______	Seizures ______	Depression/ Nerves/ Anxiety ___
Heart Disease ______	Diabetes ______	Ulcers/ Reflex ______
Heart Murmur ______	Cancer ______	Diverticulitis ______
Thyroid Disease ______	TB ______	Kidney Disease ______
Asthma/ Emphysema ______	Arthritis ______	Menstrual Problems ______
Liver Disease ______	Gout ______	Irritable Bowl ______
		Seasonal Allergies ______

OB HISTORY: Number of pregnancies ________ live births ________ miscarriages ________

SURGERIES: Write in the names and dates of any operations including tonsillectomy

Reason	Year	Hospital
1.		
2.		
3.		
4.		

HOSPITALIZATIONS: Write in dates and reasons for any other hospitalizations

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____
____

ALLERGIES: List anything you are allergic to (meds, food, bee stings, etc) and how it affects you.

____
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MEDICATIONS: Please include dosage and frequency

Name	Strength	Frequency Taken

FAMILY HISTORY: Write in the relationship of any family member (e.g., father, paternal uncle, maternal grandma) their following diseases:

High Blood Pressure ______________	Diabetes ______________
Heart Disease ______________	Stroke ______________
High Cholesterol ______________	Cancer ______________
Osteoporosis ______________	Other ______________

SOCIAL HISTORY: Please indicate your usage of the following:

Tobacco/ Chew/ Cigarettes	Yes ____ No ____	Packs per day ____	No. of years ____	Date quit ____
Alcoholic Beverages:	Yes ____ No ____	Number of Drinks per week ________		
Recreational or Street Drugs	Yes ____ No ____			
Caffeinated Beverages	Yes ____ No ____	cups of coffee per day ________		colas per day ____

Exercise Level: None Occasional Moderate High Level

Occupation: ______________________ Whom may we thank for referring you? ______________