Welcome to Davidson Clinic!

Please complete the following information. This will help us get to know you better.
Thank you, and we look forward to serving you!

Patient's Name: _____ Date of Birth: _____

Who do you live with? _____

What is your occupation/school? _____

What are your hobbies? _____

Present Medical History

List any Chronic/On-going Medical Problems	*List any allergies and the reaction*	*Medication Name* *(also bring your medication bottles)*	*Strength*	*How often do you take? Notes/Description*

Habits

Do you use tobacco products? Yes No If so, what type? _____ If so, how much? _____

Do you consume alcohol? Yes No If so, what type? _____ If so, how much? _____

How often do you exercise? _____ Anything else? _____

Preventative History

Vaccines	Approximate Date	Exams	Approximate Date
Tetanus	_____	Last Physical Exam	_____
Flu	_____	Last Dental Exam	_____
Hepatitis A	_____	Last Eye Exam	_____
Hepatitis B	_____	Last Dexa/Bone Density	_____
Pneumovax	_____	Last Colonoscopy/Sigmoidoscopy	_____
MMR	_____	Last Mammogram *(female only)*	_____
Chicken Pox	_____	Last Pap Smear *(female only)*	_____
Shingles *(over 50 years old)*	_____	Last Prostate Exam/PSA *(male only)*	_____
TB Skin Test Positive Negative	_____	Other: _____	_____

Family History

	Self	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Brother	Sister
Alcohol/Drug Abuse									
Allergies									
Anemia									
Arthritis									
Asthma									
Bleeding Disorder									
Blood Disorder (specify)									
Bronchitis									
Cancer (specify)									
Depression									
Diabetes									
Emphysema									
Gallbladder Disorder									
Gout									
Heart Disease									
High Blood Pressure									
High Cholesterol									
HIV									
Kidney Disorder (including stones)									
Liver Disease									
Lung Disease (specify)									
Mental Illness (specify)									
Rheumatic Fever									
Skin Disorder									
STD (specify)									
Stomach/Intestinal Disorder									
Stroke									
Thyroid Disorder									
Tuberculosis									
Other (specify)									

Maternal : related through the mother's side of the family

Paternal : related through the father's side of the family

Past Hospitalizations, Surgeries, Serious Injuries (including blood transfusions)

Anything else?