Plano Primary Care Clinic

Patient Name: _____

Drug Allergies / Type of Reaction

No Known Drug Allergies
Latex
Tape

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

Social History (Please Check the Appropriate Listings)

Tobacco Use
Never
Quit / When? _____
Cigarettes/Pack Per Day? ___
Pipe
Cigars
Chewing Tobacco
How many years? _____

Alcohol Use
None
Socially
Daily
Heavy
Have you ever been treated for alcoholism?
Yes No
If yes, when? _____

Drug Use
None
Marijuana
Amphetamines
Other _____
Have you ever been treated treated for drug use?
Yes No
If yes, when? _____

Exercise
None
1-2x/week
3-4x/week
5-7x/week
Type: _____

Caffeine Use
None
Occasional
Daily
How much? _____

Education (Please check highest level)

Grade School **High School** **College** **Pose Graduate**

Family History

Father	Living Deceased	Age:____	Medical History or Cause of Death	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other _____
Mother	Living Deceased	Age:____	Medical History or Cause of Death	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other _____
Brothers	# Living ____ # Deceased ___	Age:____	Medical History or Cause of Death	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other _____
Sisters	# Living ____ # Deceased ___	Age:____	Medical History or Cause of Death	High Blood Pressure Diabetes Cholesterol Cancer: Type _____ Other _____

For Females:

Are you pregnant? ____ Are you breastfeeding? _____ # of Pregnancies/Deliveries: _____

Type of Birth Control _____ Age of first menstrual period: ____ Date of LMP: _____

Last Mammogram: _____ Last Pap Smear: _____ Last Bone Density Scan: _____

For Male:

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____

Other:

Screenings: _____ Colonoscopy Date: _____