PLEASE FILL OUT THE BOX AT RIGHT >>>>

If the patient is not the COOK Employee please indicate

the insured's Name: _____

Relationship to patient: _____

If married, your spouse's name: _____

If patient is a child, parent's first and last name:

_____

PATIENT MEDICAL HISTORY: The purpose of this form is to give us an overview of your health history. Please fill this out as completely as you can, to the best of your ability. Thank you.

PLEASE PRINT **INSURANCE ID#:** _____

TODAY'S DATE: _____ **Please give your full name below; what do you like to be called?** _____

PATIENT NAME: _____, _____ M.I: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____, _____, _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SHIFT: _____ SUPERVISOR:_____

MARITAL STATUS: _____ DATE OF BIRTH: _____ AGE:_____

SEX: _____ HEIGHT:_____ WEIGHT:_____

DATE OF LAST PHYSICAL EXAMINATION:_____ BY WHOM:_____

Please list below all medications you are now taking, including non-prescription medications as well. It is very important that you list the dosage, frequency, and purpose of each one (EXAMPLE: Dyazide 50mg twice daily@ 9AM and 5PM for hypertension):

PRESCRIPTION:

_____

_____

_____

_____

NON-PRESCRIPTION:

_____

_____

_____

Please indicate if you or any BLOOD relatives have had, or currently have, any of the following diseases. Be sure to indicate WHO has the condition.

_____Cancer (Who and type)_____

_____High Blood Pressure_____

_____Diabetes_____

_____Heart Disease_____

_____Tuberculosis_____

_____Kidney Disease or Stones (Which?)_____

Please list any **medication** allergies that you are aware of (e.g. aspirin, Penicillin):

_____

_____

_____

_____

Please list any other allergies that you are aware of (e.g. bee stings, pollen, food):

_____

_____

_____

_____

Do you smoke?_____

If so, how much?_____

If you used to smoke, when did you quit?_____

Do you drink alcohol?_____

How often?_____

_____

_____

What diseases have you had, or do you have now? Please be specific.

_____

_____

_____

_____

What Surgical procedures have you had? Please indicate type of operation and date (or year), include tubal ligation, vasectomy, T&A, etc.:

_____

_____

_____

_____

Have you ever had a bad reaction following surgery, or any problem following the administration of anesthesia? Please explain:

_____

_____

_____

_____

Have you ever been hospitalized for an illness other than surgery? If so,
Please explain the reason for hospitalization, date and where hospitalized:

_____

_____

_____

_____

Please list any X-rays you have had taken in the last 2 years and indicate where they were taken (include IVP, KUB, CT, MRI, etc.) and when:

_____

_____

_____

Have you ever had an EKG? If so, please explain where, when, and why:

_____

_____

_____

Do you have a confirmed pregnancy now?_____

If so, how far along are you?_____

Is there any possibility of an unconfirmed pregnancy?_____

NAME: _____