LAKE FOREST ACUTE CARE

Patient History Form

Patient Name: _____ Date:_____/_____/_____

Reason For Visit: _____

Allergies: No Yes:

Please List:	Type of Reaction (ie. Rash, Hives, Nausea)
_____	_____
_____	_____
_____	_____

Current Medications (Include Over the Counter)

Name	Dose	Frequency (Ex. Daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:

Arthritis Gastrointestinal Kidney Problems

Sexually Transmitted Disease

Blood Disorder Genitourinary Liver Problems Skin Disorder

Cancer Heart Problems Lung Problems Thyroid

Diabetes High Blood Pressure Musculoskeletal Ear/Nose/Throat

High Cholesterol Stroke/Seizures/Neurological Other_____

Last Menstrual Period _____/_____/_____

Weight _____ Height_____ Menopause

Pregnant Yes No Unsure

Breast Feeding Yes No

Surgeries:

Head/Neck/Breast _____ Abdominal/Pelvic _____

Bone/Joint _____ Spine _____

Heart/Lung _____ Other_____

Social History:

Use of Tobacco: Former Daily < 1 Pk > 1 Pk How many years _____

Smokeless Tobacco

Use Street/Un-prescribed Drugs _____

Recent Travel _____ Education (Grade/Degree) _____

Exercise Sexually Active Yes No

Use Alcohol Never Yes Rarely Drinks per day < 1 1-2 2-3 >3

Living Status:

Married Single Widow Divorced

Live Alone Live with S.O. Parents Other _____

Family History:

	Heart Disease	Diabetes	Cancer	Other
Father				_____
Mother				_____
Sibling (s)				_____

Immunizations: Up to Date

Immunization Needed: Please Check

DTaP Hepatitis A HPV Pneumonia TB Test

Hepatitis B Influenza Polio Td (Adult Tetanus)

Hib Meningococcus MMR Rotavirus Varicella

Other _____

Preventive Screenings: Please indicate if you have had any of the following. Please indicate the date.

Mammogram _____/_____ Pap Smear _____/_____ PSA _____/_____

Colonoscopy _____/_____ Thyroid _____/_____ Cholesterol _____/_____