

Current Herbs/Vitamins/Supplements	Dose	Times Per Day

PAST MEDICAL, SURGICAL & TRAUMA HISTORY
 List prior illness, injury, hospitalization, surgery, and/or trauma:

Condition	Date(s)

IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS/STDs							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Other							

SOCIAL HISTORY (check those that apply):**Marital status:** single married divorced widowed**Education level completed:** below high school high school college professional/trade school**Living arrangement:** alone family roommate significant other**Children:** (list sex/ages if applicable): _____**Major stresses in last 6 months** Money Job Marriage Home Life Other
if other: _____**Pertinent travel history:** (out of USA, epidemic areas)**LIFESTYLE / SELF- CARE ISSUES****Do you smoke cigarettes?** YES NO If yes, how many? _____ packs per day for _____ of years.**Did you ever smoke?** YES NO If yes, when did you quit? _____ after _____ years.**Do you drink alcohol?** YES NO If yes, how much? Type _____ & _____ drinks per week**Do you drink caffeinated beverages?** YES NO If yes, which? _____**Do you use recreational drugs?** YES NO If yes, which? _____**Do you manage stress well?** YES NO NOT SURE NEED HELP**Do you exercise regularly?** YES NO If no, why? _____**HEALTH SCREENING HISTORY**

List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Colonoscopy _____

Blood test for Cholesterol _____ Blood Sugar _____ Other Blood Tests _____

Immunizations:

Tdap _____ Hepatitis _____ Pneumonia _____ Flu Shot _____

Others: _____

Recent Radiographic Procedures:

(Xray, MRI, CT Scan, Ultrasound, Bone Scan, Pet Scan, etc): Please include reason and date:

EMERGENCY CONTACT:

	NAME (list 3 contacts)	PHONE	RELATIONSHIP
1.			
May we disclose all medically needed documents to this emergency contact? <input type="checkbox"/> NO <input type="checkbox"/> YES			
2.			
May we disclose all medically needed documents to this emergency contact? <input type="checkbox"/> NO <input type="checkbox"/> YES			
3.			
May we disclose all medically needed documents to this emergency contact? <input type="checkbox"/> NO <input type="checkbox"/> YES			
Advance Directive: <input type="checkbox"/> Full code or <input type="checkbox"/> Do Not Resuscitate			

This history record has been designed to facilitate our patients continuity of care at **NW Cypress Pediatrics and Family Medicine, PLLC**. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

Patient Signature _____
Date

Printed name of individual completing form

Signature of individual completing form _____
Date

Advanced Practice Nurse Consent For Treatment

This facility has on staff an advanced practice nurse of assist in the delivery of medical care. An advanced practice is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as wells provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician **if a physician is available.**

Patient/Guardian Name (Print)

Date

Patient/Guardian Name (Signature)