FP Associates, P.C.

Name _____ **Date of Birth** _____

Allergies

_____
_____
_____

Medications

_____
_____
_____
_____
_____
_____
_____
_____

Operations (list year)

Ear Tubes	____	Breast Biopsy	____
Tonsil/Adenoids	____	D & C	____
Gall Bladder	____	Hysterectomy	____
Appendectomy	____	Ovary(s)	____
Vasectomy	____	Tubal Ligation	____
Hernia	____	Joint Surgery	____

Other Operations and Hospitalizations:

_____
_____
_____

Social History

Occupation _____
Married _____ Children (number) _____
Single _____ Divorced _____ Widow ____

Tobacco _____ per day, for _____ years
(includes cigar, pipe, chew)
Never _____ Quit _____

Alcohol _____ per week
(specify *type* and *amount* used)
_____

Immunizations (list year received)
Tetanus _____
Hepatitis B* _____ *3 shots to complete series
Pneumonia _____

TB Testing _____
Positive _____ Negative _____

Family History and Personal History

Self		Dad	Mom	Brother	Sister
	Allergy - Hay Fever				
	Asthma				
	Bleeding Disorder				
	Cancer, Breast				
	Cancer, Colon				
	Cancer, Lung				
	Cancer, Prostate				
	Cancer				
	Diabetes				
	Depression				
	Emotional problems				
	Epilepsy/Seizure				
	Heart Attack				
	High Blood Pressure				
	Kidney Disease				
	Liver Disease				
	Migraine				
	Stroke				
	Thyroid Disease				
	Tuberculosis				

Deceased Family - list cause of death and age if known
Father _____
Mother _____
Brother / Sister _____
Spouse / Children _____

Optional
Do you have Advance Directives / Living Will? _____

Religion
_____

Additional Information
_____
_____
_____