Coddington Medical Family Practice

Today's Date: _____

Name: _____ Date of Birth: _____

Reason for Visit: _____

Preferred Pharmacy: _____

Past Medical History: (If you need more paper ask Front Desk)

Medications: (Any Prescriptions, also Birth Control, Herbals, Vitamins, Supplements, and Over the Counters)

Name	Dosage	Frequency

Allergies: (Medications and/or Environmental)

Name	Reaction

Surgical History:

Surgery	Date

Heath Care Maintenance/Screenings:

	Date
Colonoscopy	/ /
Mammogram	/ /
Pap Smear	/ /
DEXA/Bone Density	/ /
Stress Test	/ /
Prostate Exam	/ /
Eye Exam	/ /
Diabetic Foot Exam	/ /
Depression Screening	/ /
Alcohol Screening	/ /

Immunization: (Provide Records if Available)

	Date
Flu	/ /
Pneumonia	/ /
Hepatits B	/ /
Tetanus	/ /
HPV	/ /

Social History:

Do you Smoke?	☐ Yes	☐ No	☐ Never	----------	If yes, how much per day?
Chew Tobacco?	☐ Yes	☐ No	☐ Never	----------	If stopped tobacco use. Quit Date?
Drink Alcohol?	☐ Yes	☐ No	☐ Never	----------	Drinks per: /day /week
Caffeinated Drinks?	☐ Yes	☐ No	☐ Never	----------	Cups/Cans per: /day /week
Do you Exercise?	☐ Yes	☐ No	☐ Never	----------	Type: _____ Days per Week: _____

Family History:

Disease/Health Condition	Family Member(s)
Alzheimer's/Dementia	
Cancer	
COPD/Asthma (Chronic Lung Disease)	
Diabetes	
Heart Disease	
High Cholesterol	
Hypertension (High Blood Pressure)	
Mental Health Issues	
Stroke	
Thyroid Problems	
Other	